JOURNAL

of the

AMERICAN PODIATRY ASSOCIATION

ANNUAL MEETING
WASHINGTON, D. C.
AUGUST 22-26, 1958

The Official Publication of the Podiatry-Chiropody Profession

Hypnosis

Ungual Elevator

Testing Foot Strength

Newer Local Anesthetic

Protective Device for Athletic Shoes

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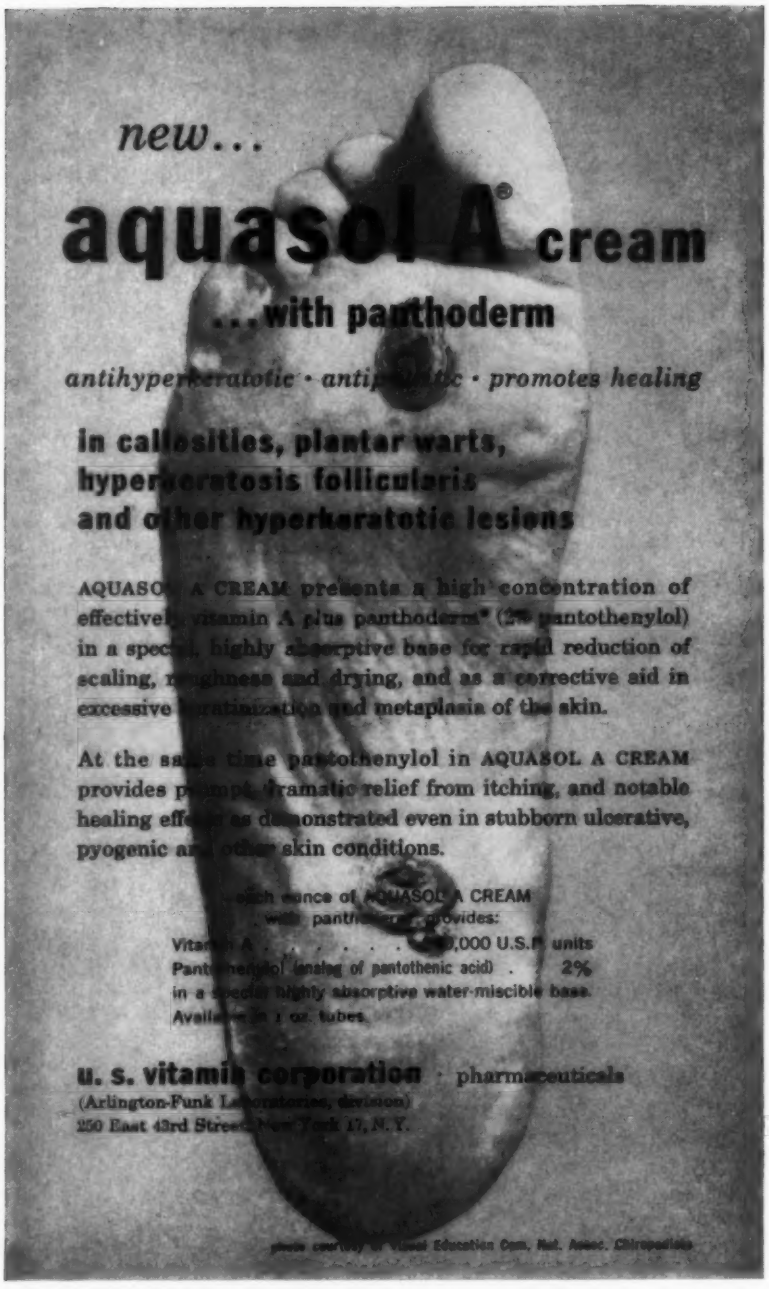
VOLUME 48, NUMBER 2 FEBRUARY, 1958



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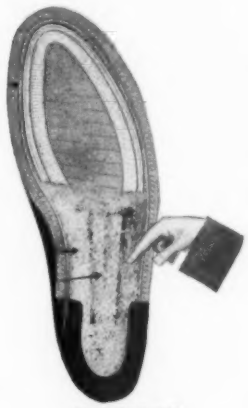

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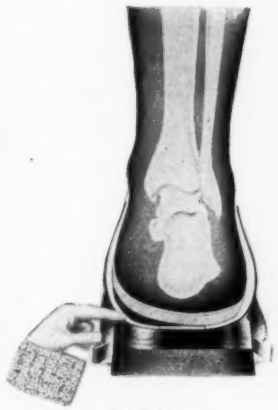

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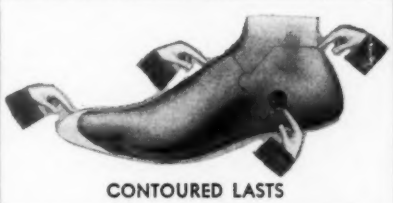

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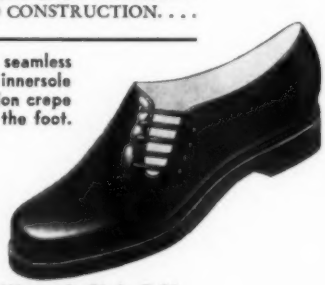

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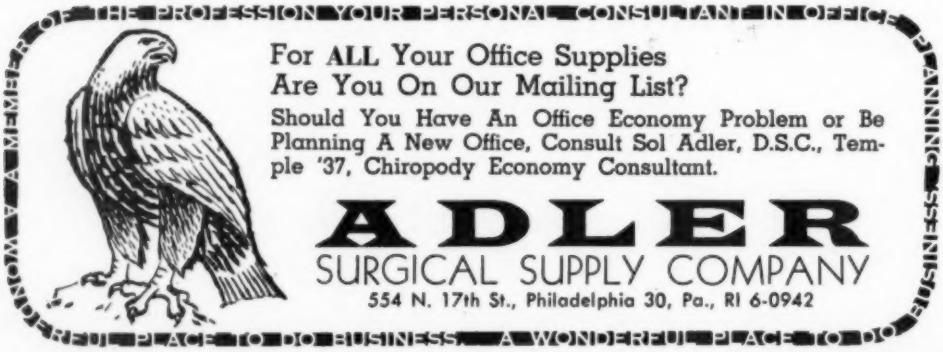
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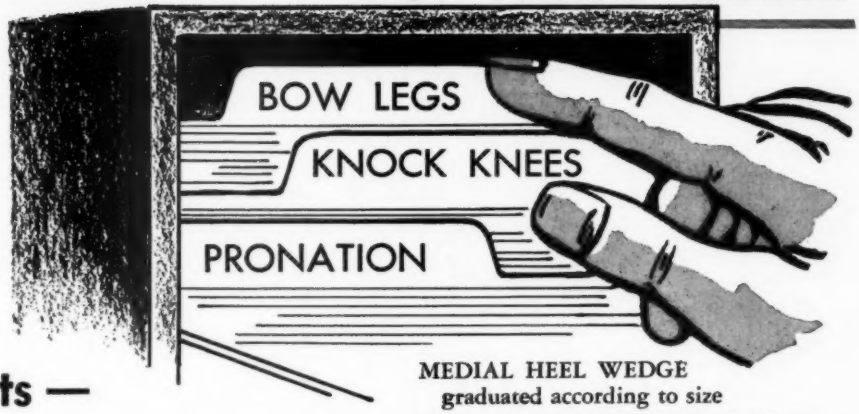

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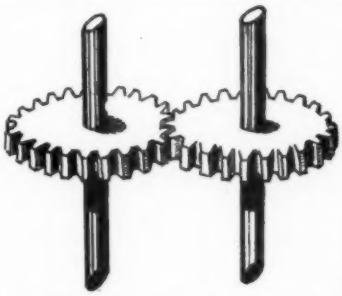

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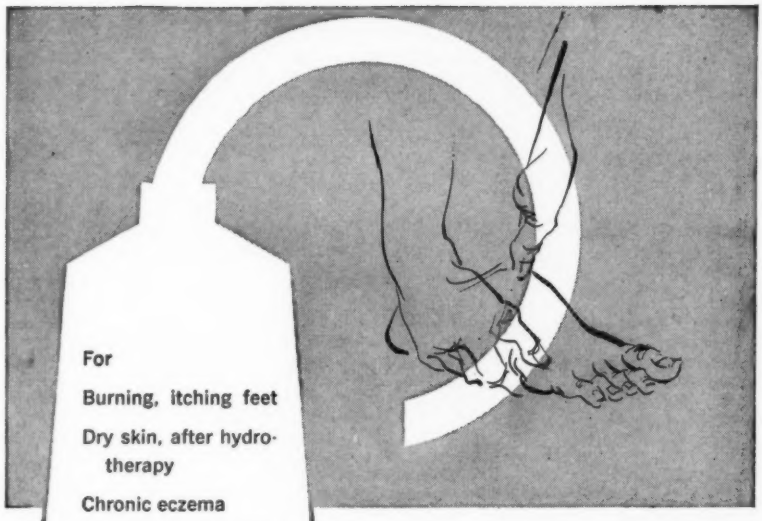

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VOLUME 48 FEBRUARY, 1958 NUMBER 2

ATRAUMATIC NAIL AVULSION WITH A NOVEL UNGUAL ELEVATOR*

LAWRENCE FROST, D.S.C., F.A.C.F.S.
Monroe, Mich.

The very nature of foot surgery is such as to require instruments adaptable to the many problems encountered. The augmented tactile sense of the chiropodist demands instruments that can be handled with great dexterity and a minimal amount of trauma. Many of the instruments presently used have been adopted from the allied specialties and have served the purpose admirably. Some are of a makeshift nature, and will remain so, until such time as chiropodial ingenuity fashions more suitable ones. Such has been the case where it became necessary to surgically avulse the nail.

Under certain circumstances it becomes necessary to avulse the nail. When this point is reached a difficult decision is that of technique. A number of methods have been described in the literature but each leaves the surgeon with the feeling that unnecessary traumatization will result. The less trauma the less chance of a thickened or deformed nail.

Historical

Commonest of the avulsion techniques is that of inserting a closed scissors under the nail[1] and then opening them. Another procedure is that of inserting the blunt end of a scalpel under the nail plate. One author[2] advises you to grasp the nail with a heavy hemostat and loosen it from its attachments at the posterior portion, and another[3] that you should loosen the skin, push it back, and then twist over the nail and remove it. A method frequently employed[4] is that of forcing a small periosteal elevator under the nail to free it and then twist it off with a hemostat. Lewin[5] suggests the use of his bunion dissector, while Pardo-Castello[6] believes mechanical removal may be necessary. Perhaps the most unusual[7] technique offered is that of injecting hyaluronidase under the nail and then removing it by traction once it has loosened.

The writer has used most of the methods outlined and, in doing so, realized that traumatization of the matrix could result in a thicker or deformed new nail. It was concluded that an atraumatic avulsion instrument properly designed should have a blunt distal end so that its insertion under the nail plate could not traumatize the soft tissue, yet separate the nail plate from the nail bed through the normal line of cleavage. The instrument was gradually

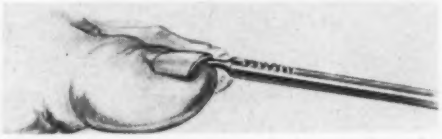

Fig. 1. Ungual elevator is inserted under the inferior surface of the nail plate along its midline.

*Presented at N.A.C. Annual Meeting, Chicago, August 1957.

increased in thickness so that as it advanced under the nail plate it would elevate it much as a chisel splits wood. This was aided by a slight convexity of the body of the instrument on its superior aspect. By trial and error the instrument illustrated became the end result.

Fig. 2. Once the elevator has passed under the entire length of the nail it is moved from side to side.

Uses

In application this ungual elevator was found to have many uses:

1. Ungual avulsion in tinea unguium and other ungual diseases.
2. Ungual avulsion prior to subungual exostosectomy.
3. Ungual avulsion for onychauxis and onychogryphosis.
4. Ungual avulsion prior to a nail root excision.
5. Metatarsal elevator in a plantar condylectomy (DuVries).
6. Blunt dissection.
7. Deep retraction.

Technique

1. Grasping the ungual elevator so the thumb rests on the transverse grooves the instrument is inserted under the nail. (See Fig. 1.)
2. Once the elevator has passed under the entire length of the nail (See Fig. 2.) it is moved from side to side as if on a swivel through the center of the nail plate.

Fig. 3. Loose nail plate is lifted off the nail bed.

3. Remove thumb from the elevator placing it on the dorsum of the nail plate, then remove nail plate. (See Fig. 3.) Debride superfluous tissue from the nail bed or either sulcus with great care.
4. Telfa®[1] is placed over the nail bed and a light dressing applied. Where the avulsion was performed for a tinea infected nail, redressings are done at five day intervals. Once the surface is healed the patient is instructed in the use of a fungicide on the area in order that the new nail may have a fungous free surface on which to thrive.

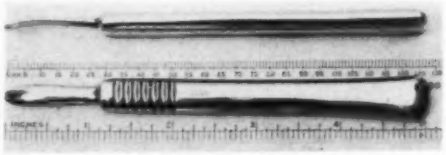

Fig. 4. The instrument is one-half actual size.

Summary

1. Nail avulsion techniques have been long fraught with procedures that tend to injure nail germinating tissues.
2. An instrument has been devised that is simple to use with little danger of traumatizing important structures.
3. The shape and balance of the instrument is such as to be quite useful in several other foot surgery procedures.
4. With the vast increase in tinea un-

[1] Bauer & Black

guium its treatment by avulsion may now be considered with impunity.

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FOOT PROTECTION DEVICE FOR USE IN ATHLETIC SHOES†

IRVING YALE, D.S.C., F.A.S.C.R.*
Ansonia, Conn.

THE author, in his experience of caring for foot disability resulting from trauma, has experimented with therapeutic variations to relieve pain. Observation has resulted in an evaluation of the source and site of foot discomfort in athletes. This paper is specifically concerned with basketball injuries to the feet but may well be considered in an approach to disability in all forms of athletic endeavor.

Chiropodists have been treating the sequelae of athletic injuries in their acute and subacute stages by the use of physical modalities, strapping, shielding and padding with variable results. A strapping properly applied to relieve strain and to support traumatized structures has been successfully used by all of us who treat feet. Shielding and padding have afforded immeasurable comfort where indicated. What has been done to assist in the prevention of the foot disorders brought about by athletic stress?

Specifically, players and doctors have noted that the parts commonly affected are the contused heel, strained plantar fascia and flexor muscles, sprained lateral ligaments of the ankle and injuries to the sesamoid bones beneath the head of the first metatarsal. A sponge heel pad has often relieved the heel; a strapping to shorten the distance of origin to insertion has aided in resting the plantar fascia and flexor muscles; an everted foot held by adhesive gives comfort in sprains of the lateral ligaments and a pad with a cutout for the sesamoids removes pressure from these painful members.

A pad or new construction was found necessary for the protection and prevention of these definite injuries to the feet while encased in the rubber and canvas shoes commonly used for playing basketball and other sports. Injuries to feet can be ameliorated and often prevented through wearing properly designed footgear.

Current developments in the canvas, leather and rubber shoe industry have not considered the need for such prevention and protection resulting in the continual abuse of the privilege of making footgear for our American youth.

Basketball players jumping rather high come down on their heels hard with the greatest trauma occurring beneath the medial tubercle of the os calcis. A contusion, bursitis or even spur formation may develop at this site with repeated injury.

Sudden stops often result in such great stress on the lateral ankle structures that ligamentous strain and tears are quite common.

The flexibility of rubber and canvas shoes while being used on hard, resistant,

†Honorable Mention, 1957 Wm. J. Stickel Annual Awards for Research in Chiropody.

*Consultant in Chiropody, Orthopedic Section, Yale University Medical School, and in Department of Roentgenology and Diagnosis, Illinois College of Chiropody.

unyielding surfaces precipitates strain throughout the plantar fascia.

Pivoting on the ball of the foot produces multiple minimal trauma to the sesamoids often causing either a contusion, bursitis, sesamoiditis, tear of fibrocartilaginous attachments of bipartite sesamoids or fracture and dislocation.

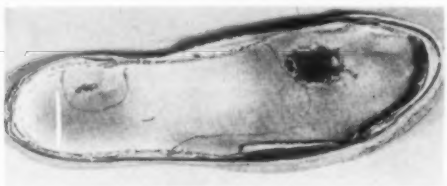

Fig. 1.—Typical Wear in Right Basketball Shoe, Device Outlined.

Many devices have been invented to cope with one or more of these problems but few consider the most prevalent site of injury and stress. Most applications in shoes are constructed for support of a static foot rather than protection of the dynamic pedal extremity.

A review of the literature and patent specifications suggests the static nature of the approach of others to this problem.

Frei and Kasser[1] describe their "Shoe With Orthopedic Insertion" in the following manner. "This invention relates to shoes provided with supports which are fixed in the soles below the socks.

"According to this invention the supports which are made of non-metallic materials are each of tapered cross section from one side towards the other and have an upper surface curved to conform to the sole of the foot and comprising a main portion extending the whole of the width of the foot from the front of the heel to the metatarsus and having a prolongation from one side to the back of the heel.

"These supports are placed in the shoes during the manufacture of the shoe and may of course be inserted into already made shoes by lifting the socks therein and placing the supports in position and refixing the socks, it being understood of course that the curved upper surfaces above referred to may be varied as required."

Garnett O. Skinner[2] has a patent for a "Foot Cushion." His description and claims are as follows. "The invention relates to improvement in foot cushions.

"An object of the invention is to provide a novel foot cushion construction in which the longitudinal, transverse, and metatarsal arches are flexibly supported."

Frederick Kornder[3] describes his specifications for an "Insole Support" as follows:

An insole and arch supporter formed of a single piece of resilient rawhide of even thickness throughout, adapted to be fitted to a foot and worn with an ordinary shoe, having its lower portion suitably shaped to conform to the heel, arch and ball of the foot, and having side wings extending upwardly to embrace the upper inner and outer sides of the foot, and a waterproof substance covering the entire surface of the rawhide.

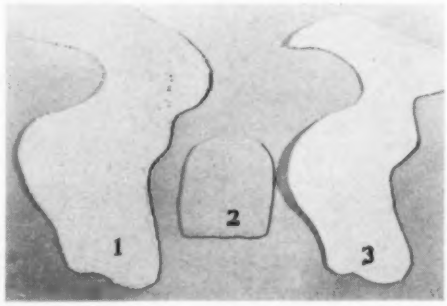

Fig. 2—Materials and Design Used in Construction.

1. Canvas Covered Rubber.
2. Sponge Heel.
3. Celastic Shell or Rubber Stiffener.

One manufacturer has been so concerned about giving the athletic world a bigger, better and higher arch construction that he has unwittingly caused foot trauma. The arch being raised unduly with the foot placed in extreme inversion creates great stress on the lateral ligaments of the ankle.

Sudden stops have caused ankle twists with tear of the lateral ligaments and muscles.

Another shoe builder has used a sole with so much traction that sprains of the ankle were inevitable on quick turns and stops.

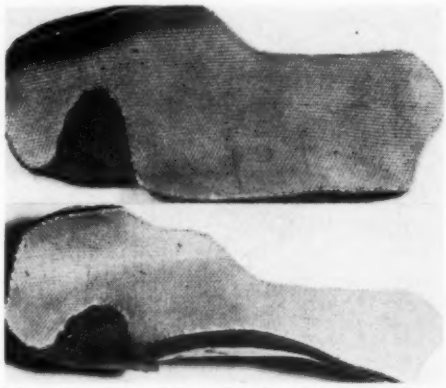

Fig. 3U.—Top View Device for Left Shoe. Protection Device Completed and Ready for Adherence to Shoe.
Fig. 3L.—Top and Side View.

A so-called modern approach has developed still another construction which embodies a hard wedge under the medial aspect of the calcaneus to compensate for rotation of the heel. This device has contributed to innumerable contusions to the heel resulting in bursitis, periostitis and incipient spur formation. A wedge of this type was never meant for a dynamic foot governed by the oft repeated athletic term, "on your toes."

Most athletic shoe designs incorporate a sponge innersole. The spongier the weight-bearing surface the more protection the foot was supposed to receive upon being subjected to trauma. The fallacy here is that the greater the bounce the more muscular fatigue has been the result.

Thus, we who treat hundreds of thousands of foot sufferers each year must fully realize that there is a need for our knowledge and background as advisers to the shoe industry. We cannot hope to make better shoes for that is the job of the shoemaker. We can, however, evaluate the construction and design as to its potential value as an instrument of foot health.

The writer has developed a "Protection Device for Athletic Shoes." It is based on the time-tried techniques that chiropodists have used for years to relieve discomfort. The art of shielding and weight distribution is utilized. Certainly the need is great. The writer is sure this is not a panacea, and that his present method of construction can be improved upon if properly incorporated into athletic footgear.

The protection pad protects the medial tubercle of the calcaneus from serious bruising, periostitis, bursitis and spur formations which may develop from athletic injuries when wearing inadequate shoes. The fibrous plantar fascial structure, especially

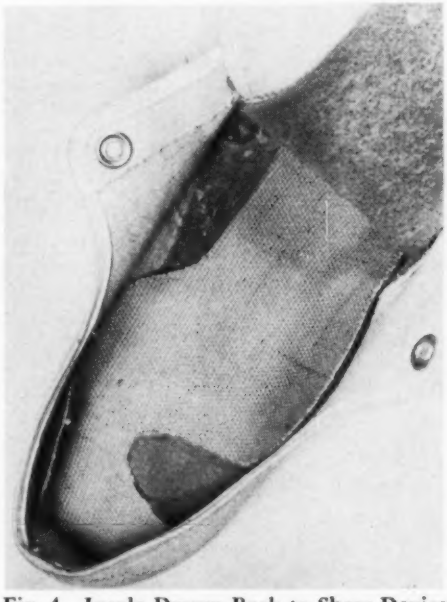

Fig. 4.—Insole Drawn Back to Show Device in Shoe.

the medial and middle portions, are relieved of the strain that most presently designed "sneakers" produce. The pad is so constructed that ankle sprains can be minimized while maintaining adequate balance

of the foot and the arch. The sesamoid bones under the first metatarsal head are protected in such a manner that pivoting becomes effortless and without subsequent pain and blister formation.

Simplicity of Manufacture

This device can be manufactured inexpensively requiring a minimum of material, labor and time. It can be used on existing lasts requiring no readjustment of manufacturing technique in shoe composition.

Method of Manufacture

Materials—Celastic, celastic activator, or other firm rubber or plastics, canvas covered rubber and sponge rubber.

Procedure—Previously cut patterns of celastic are dipped in the activator and allowed to partially dry. The patterns are shaped over the last or directly in the shoe, whichever is deemed speedier. A sponge heel pad covers the heel seat and the entire pad is covered by the canvas topped rubber. All of this is placed under the insole which acts as a covering.

Any rubber or plastic material of the same or similar consistency and design may be used instead of the celastic. This will facilitate manufacture of those shoes completed on a last and placed in the heating rooms for vulcanization and fusing of parts.

The accompanying photographs illustrate the need and proper placement of the device.

It is the writer's sincere hope that the profession can benefit by the use of this method of protecting feet from athletic stress.

44 East Main St.

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THE FOOT SPECIALIST'S ROLE IN THE RECOGNITION OF RHEUMATIC FEVER

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A review of a series of thirty cases of rheumatic fever seen at an Army installation* from September 1956 to June 1957, reveals a consistent and striking dissimilarity of joint manifestations as compared with the descriptions given in the standard references. Literature on the subject of rheumatic fever is voluminous. Most texts[1,2,3,4] superficially describe the joint phase repeating the often quoted description of a migratory polyarthritis with redness, heat, swelling and pain.

The incidence of joint involvement in this series is limited to the ankles and knees. Perhaps this accounts for the relatively large number of cases that originally have been seen, tentatively diagnosed and referred from the Foot Clinic to the Medical Service for complete evaluation and treatment. In all of these cases we have not observed the typically described joint syndrome of a migratory (fleeting) polyarthritis with redness, heat, swelling and pain.

The usual clinical case seen at the Foot Clinic is that of a white male, age 17 to 25, with a chief complaint of pain in one or both ankles or heels, and perhaps a less severe and vague pain in one or both knees. Examination of the ankle reveals edema circumscribing the joint and heel area with a fullness of the posterior triangle. The local skin temperature is elevated and an erythema about the involved joint is usually not seen. The synovial

*United States Army Hospital, Fort Dix, N. J.

membrane appears easily palpable, thickened and spongy. Pain is elicited on palpation of the joint margins and also at times at the medial and lateral surfaces of the posterior of the os calcis up into the posterior triangle. The ankle is able to achieve about 20 to 30 degrees of flexion-extension without symptoms and it is only upon extremes of this motion that pain is produced. Examination of the vascular, neurological and mechanical system is non-significant. X-rays are negative except for a possible soft tissue swelling. Usually there is an increased pulse rate and infrequently a cardiac irregularity as evidenced by a skipped beat.

Deviations from the above findings include one case with a vague left wrist involvement, two cases with petechiae at the ankle, and one patient with frank redness and extreme pain of one ankle.

A careful history reveals a recent upper respiratory infection; perhaps described as a long-standing common cold. The onset of joint involvement is rather acute, the patient being unable to volunteer an obvious cause. The family history not infrequently shows unexplained cardiac or rheumatic involvement.

There is little doubt that this disease syndrome at its onset may be comprised of so many irrelevant symptoms that unless correlated may never suggest a diagnosis of rheumatic fever. The first few cases seen by us caused great consternation as to the exact diagnosis. After considering trauma, tenosynovitis, gout, cellulitis, rheumatoid arthritis, gonorrheal arthritis, septic arthritis, synovitis, etc., and finding combinations of increased body temperature (up to 102°), increased pulse rate (to 124), increased sedimentation rates (to 54), generalized weakness, and a history of upper respiratory infection, we proceeded to refer them to the Medical Service. They were admitted with a provisional diagnosis of rhuematic fever and subsequent observation and treatment confirmed this diagnosis.

A cursory examination by the Medical Service almost always revealed heart involvement. Initial ECG studies usually presented typical alterations of heart waves associated with rheumatic fever. An interesting observation in 4 cases whose ECG's were normal upon admittance, has been the appearance of the typical cardiac-rheumatic pattern while on bed rest and after subsidence of joint manifestations. The sedimentation rate remained elevated though the joints improved. Complete bed rest and the administration of salicylates brought about a rapid resolution of joint pathology.

Summary

A series of 30 confirmed cases of rheumatic fever in the age group 17 to 25 has been reviewed. The clinical and laboratory findings in these cases are identical with those found in standard texts excepting for the descriptions of the joint affection. In not one case did we observe the usually described migratory polyarthritis. Redness about the affected joint was not seen. The degree of pain and of range of motion at the joints were variable. Increased local skin temperature and swelling were frequently present.

Conclusion

Early diagnosis and proper treatment of rheumatic fever greatly enhances a favorable prognosis. Neglect or delay may lead to permanent cardiac damage. It behooves the podiatrist to be cognizant of the joint involvement as an early warning sign. This is a frequent clinical sign in our own field.

318 DeForest Rd.

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THE PODIGAUGE: AN OBJECTIVE METHOD OF TESTING FOOT STRENGTH

Preliminary Report†

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IN PODIATRY today, cognizant as we are of the value of thorough diagnosis as an indispensable preliminary to adequate treatment, we employ various instruments to help accomplish this end. Among them are the X-Ray, Podiascope and Chirometer. The determination of the line of the Tendo Achilles, the height of the arch, the scaphoid differential together with foot pulse, color and temperature, position of toes, neurological tests, etc., also clinically help us to evaluate the foot we are treating.

One of our leading foot specialists[1] expressed the feeling of most of us in the field when he said, "we have never developed to the fullest possibilities the foot test under actual working conditions. Up to the present time we still rely on past experience, trial and error and other minor points for our functional corrections. It is this phase of our work that needs immediate attention."

In discussing the body under actual working conditions we can refer to the research done by some of the leading authorities in the Physical Health Education field. In discussing postural measurements (which includes work on the lower extremities) we find invariably they have learned to insist that working with instruments is consistently superior to working with subjective judgments. Cureton[2] found that "instrumental measurements are four times more reliable and objective than judgments."

H. H. Clarke wrote,[3] "The regular use of measurement is one of the most distinctive marks of the professional viewpoint in any human activity . . . particularly in engineering, medicine and physical education. . . . The scientific construction of these tests in the field of health and physical education is still so relatively recent that a willingness to use existing tests and to analyze them critically is essential to the growth of this movement and to the profession itself."

In measurement application we find that in evaluating a test the following criteria are used:[4]

a) The need for precision (accurate measuring instruments).
b) Reliability (degree of consistency with which a measuring device may be applied).
c) Objectivity (the degree of uniformity with which various individuals score the same tests).
d) Norms (depending on age and height).
e) Economy (money and time).

One of the measurement tests developed by Cureton gave ten points for evaluating foot function.[5]

a) Vertical Jump (a white button is attached to the ankle). Subject stands in front of a background of paper with horizontal lines. The line behind the white button is called the zero mark. The subect jumps as high as he can. The height of the button compared to the line reached reveals the height of the jump. Another similar test along the same lines is the "Bounce Test" which was used on college women. From squat position (straight back, arms grasping instep, knees immobilized) to rise to end of toes (almost a jump) following a definite rhythm given by the timer. Score is total number of bounces minus lost counts.[6]

b) Scaphoid deviation (the basic principle is to measure the inward bulging of

†Presented at the N.A.C. Annual Meeting, Chicago, 1957.

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the scaphoid bone beyond the line connecting the inner side of of the heel and the base of the big toe with blocks held tight against the foot).

c) Center of gravity test (balancing board on two fine edges, foot in center).[7]

d) Foot extension strength (subject standing on scale, straps around neck and shoulders extending down to beneath scale, presses down on scale).

e) Height of scaphoid bone (the most prominent part of the scaphoid is marked with flesh pencil and measured).

f) Height of internal malleolus (from ground to most prominent point in lower edge of internal malleolus).

g) Little toe flexion strength (a press block is placed perpendicular to the central axis of the foot so that the little toe can just exert its pressure on the block).

h) Great toe angle and lever ratio.

i) Width of malleoli and foot.

j) Arch angle.[8,9]

Measurements a, b, c, e and g are considered the most important.

Additionally we find in the Health Education field that other methods of testing various strengths are of interest to us. For example, Clarke adopted an aircraft control cable tensiometer for testing affected muscle groups involved in various orthopedic disabilities (wrist, elbow, shoulder, hip, knee and ankle.) This very precise apparatus measures from five to three hundred pounds. However, in our specialized field the fact that the Clarke tensiometer test does not measure under five pounds and since most of our scores, especially on older people, fall below the five pound mark means that we cannot effectively make use of this test in our specialty. Additionally we find that the necessity for two examiners to give the test is a definite drawback. The first limitation is also one of the chief limitations to the use of the Sharpe dynametric sole[10] in the foot health field.

A second test of interest to podiatrists is Cureton's Average Ankle Flexibility Measurement.[11] The subject sits on the floor with both legs extended. A board is placed on the side of the foot adjacent to the internal malleolus. Using a protractor and keeping the heel stationary the top of the foot is traced in maximum extension and then flexion positions (pencil is kept horizontal).

These tests used by Physical Educators, Orthopods, etc., have proven to be of value in objectively determining degree of muscular efficiency. After surveying these reports it becomes obvious that up to now there has been no objective test for measuring the degree of muscular strength of the foot.

Cognizant of the need for such a diagnostic modality I herewith present a report of an instrument (which I shall henceforth refer to as the Podigauge) which can be employed to objectively measure foot strength to a minute degree. The following is presented as a preliminary report of a simple, inexpensive method of scientifically evaluating the strength of the lower extremity.

The following have been the chief tests which have been followed in this research study:

1) The strength of the plantar flexors of the toes.
2) The strength of the "adductors" of the forefoot.
3) The strength of the "abductors" of the forefoot.
4) The strength of the foot dorsi-flexors.
5) The strength of the foot plantar flexors.

The Podigauge (Fig. 1) consists of a wooden platform to which is secured two finely calibrated spring scales. The first (upper right) is a three-pound scale divided into ounces. The second is a forty-pound scale divided into half-pounds. In the center is a ball-bearing pulley held in place by two pillow blocks which are attached to

the platform by hand screws. On the left, starting from top to bottom, are the toe-bar, the bar for testing the foot dorsi-flexors, the loop for testing abduction and adduction of the forefoot and at the base, the cloth lever for testing foot plantar flexion.

To test the plantar flexors of the toes the following technique has been employed. The right foot is placed on the platform with the toes facing the Podigauge. The sulcus between the ball of the foot and the toes rests on a bar which is grasped by the foot.

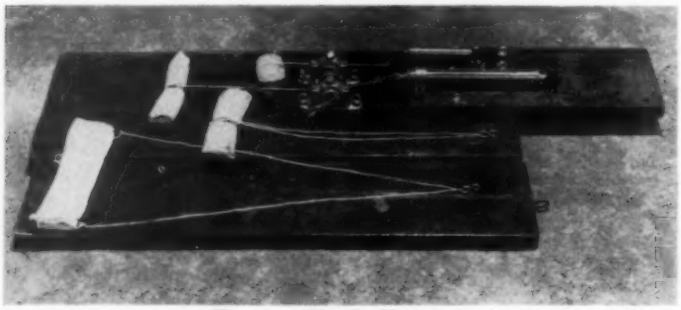

Fig. 1 — The Podigauge.

(The bar is connected to the Podigauge by thin nylon line.) The patient is then instructed to pull the bar away from the Podigauge, during which time the heel is maintained in a stationary position. After two practice tries the third try is performed. By this time the patient has learned what it is that he is endeavoring to achieve and usually shows an added understanding and enthusiasm. The examiner, on the third try, checks the reading on the Podigauge and records the highest excursion of the instrument marker under the heading "R T PL F" (right toe plantar flexion). In dealing with adults of normal health I have used the forty-pound scale. For testing those with very little muscular power the three-pound scale, which is subdivided into ounces, is used.

The next test consists of "adduction" of the forefoot. The foot is placed in front of the scale and at right angles to it. The little toe is toward the scale, the big toe is farther away from it. The nylon cord which is attached to the scale on one end encircles the forefoot at the other end. Keeping the heel firmly in place (assisted by the examiner) the forefoot is moved away from the scale on as level a plane as possible. At the third try the examiner records the highest mark of the Podigauge.

To test the "abduction" of the forefoot the right foot is placed at right angles to the Podigauge, the large toe nearest the scale, the little toe farther away from it. The nylon again encircles the forefoot and the forefoot is moved (as near as possible on the same plane) so that the little toe side moves away from the scale (heel immobilized). As before, the third try is scored as the official endeavor.

To measure the strength of the dorsi-flexors of the foot we place the foot on the platform, toes facing the scale. The bar is placed on the dorsum of the foot just proximal to the toes. The line that is attached from the scale passes from the bar down between the first and second toes forward underneath the ball-bearing pulleys and then fastens to the scale. The heel is kept on the platform, the front of the foot is raised (dorsi-flexed) to the maximum. The knee is kept extended. The finding is recorded as previously.

To determine the strength of the plantar flexors of the foot the apparatus is placed in a vertical position about three and one-half feet from the floor. The heel of the foot rests on a platform about six inches high. The ball of the foot rests on a lever (cloth) which is attached to the scale. Then the testing procedure is followed.

In my practice, I have found the Podigauge of value in gauging the degree of

TABLE I

TEST SCORES

Subject	Sex	Age	Ht.	Wt.	PTF	AB	ADD
B.A.	M	64	5'11½"	145	R½	2½	3
					L½	2½	1½
C	F	52	5'3"	123	R1	2¼	½
	(Parkinson's 10 yrs. ago)				L½	2	1
K	F	45	5'3"	130	R2½	5	6
					L2½	5	7
S	F	57	5'1"	94	R½	4	3
					L¾	3	2
W	F	40	5'1"	112	R2½	4	4
					L4	4½	7
R.N.	M	7	49"	59	R1	5½	1½
					L1½	5	2½
A.N.	F	10	54"	88	R3	2½	3½
					L2½	4½	2
B.P.	M	59	5'10½"	200	R4	5	2½
					L3	4½	5
X	M	49	5'8"	165	R1½	5½	5
					L1	8	10
W	F	29	5'6"	128	R4	5	5½
					L2	4½	4
E	F	20	5'4"	130	R7	7	5
					L7	6	5
S	M	27	5'10½"	175	R4	5½	6½
					L4	7	6
T	F	17	?	125	R4	6	5½
					L4½	6	6
S	F	9	52"	52	R4	8½	7½
					L5	8	8
L	M	40	5'10½"	200	R4½	11	3½
					L5½	7	7
G	M	26	5'7½"	176	R9	15½	15½
	(Limitation of Flexion)				L9	14½	13

PTF – Plantar Toe Flexion
AB – Abduction
ADD – Adduction
T, Foot Plantar Fl. R5, L3½
S, Foot Plantar Fl. R5, L4½ Dorsi-Flexion, R6½, L6
L, Dorsi-Flexion, R14, L10
G, Foot Plantar Fl. R5, L5 Dorsi-Flexion, R13, L15

progress (in terms of muscular strength) after indicated therapy has been instituted. (For details of therapy refer to "Techniques on Foot Rehabilitation."[12]) One is thus objectively able to gauge (and illustrate) measurable improvement in foot power in terms of minute degree.

Table I contains data on a group of patients selected at random and indicates scores achieved in foot tests. It is hoped that the profession may feel that this test has enough merit to begin measuring foot strength of individuals so that large groups may be thus tested. Once enough tests have

been made so that standards may be established we will be able, when a patient enters the office, to evaluate his feet and compare his record with others of his height and age and tell him immediately whether his feet are within the desired norm.

It is my feeling that this diagnostic adjunct can open an avenue of productive research which may further help us to more accurately evaluate and hence to treat the foot problems with which we are confronted daily.

One De Kalb Ave.

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INDUCING HYPNOSIS IN THE WAKING SUBJECT

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There is a universal lack of scientific interest in this subject shared by all branches of medicine, but the chiropodist has shunned hypnosis because of several special reasons. Most important among these are: (1) The question about his moral and legal right to use hypnosis. (2) The mental attitude of the patients when they present themselves for treatment. (3) The lack of adequate training programs. (4) The time-consuming and cumbersome techniques which are presently being used to induce hypnosis.

Hypnotherapy still holds a precarious position in the field of medicine, even though it has been used therapeutically for almost two hundred years. It however is continuously proving its legitimacy, and is a valuable tool in all branches of the healing arts. It has, like any other therapeutic agent, very definite limitations, but there are no substitutes for its use in many instances. This is especially true in the treatment of children.[1] In the writer's opinion hypnosis has a greater therapeutic potential in chiropody than it does in any other phase of medical practice. This is primarily due to the nature of the problems with which we are confronted; and like so many other forms of therapy, medicine and dentistry have shown us the way, and we merely have to adopt the proven principles to our field. The chiropodist will find those methods employed by the dentist[7] very applicable to his own field, because the parallels between the two professions are more extensive than previously illustrated.

The writer has obtained evidence which indicates beyond doubt that hypnosis does not exist as an entity, and without greatly modifying previous information the whole phenomenon may be explained. The hypnotic trance is synthesized by the applica-

tion of several unrelated suggestions, and it is not important to the production of any of the so-called hypnotic responses. The phenomena are the result of reflexes which have been conditioned to respond to key words,[16] and they are present in almost every individual. Furthermore, since it is so permanently established in hypnotic literature, "suggestion" may be considered the manner in which these conditioned reflexes are provoked. However, in continuing the use of this word, we must remind the reader that none of the vague explanations offered by Bernheim,[3] et al, are entirely accurate. Previous concepts of suggestion have been based upon behaviorism, and these pseudoscientific explanations tell us nothing about the neurophysiological mechanism involved in the production of the hypnotic phenomenon. When Bernheim said, "there is no hypnosis; there is nothing but suggestion!" he may as well have added, "there is no sun; there is nothing but sunshine!" If the term is to be retained *heterosuggestion must mean the process of inducing a conditioned reflex, both mental and physical, by the proper use of physical, electrical, chemical and/or word stimuli. Autosuggestion is the production of conditioned reflexes by subjective thought.*

Before the conditioned reflexes can be elicited by suggestion the subject must be "suggestible," and this is dependent upon belief, confidence and expectation.[6] Therefore, if we have a subject who believes that such responses are possible, and has confidence in his ability to produce these phenomena (or in the hypnotist's ability to make him perform), he then expects to respond and the conditioned reflexes may be elicited by the use of suggestion—which, in most cases, the stimuli are words. In all cases the subject receives the stimulus and responds autonomously. His manner of responding differs in no way from the method in which he produces mental and physical activity during daily living[9, 10, 11, 14] and the only reason why he does not produce these hypnotic responses normally is because he does not approach new activities with a positive attitude and is not in a suggestible state. When, however, the essential factors are unilateral he will produce such responses, and the list of phenomena observed by various investigators is amazingly complete.

The obstacle of moral and legal complications need not intimidate the chiropodist, because the modern chiropodist is well qualified to meet the obligations that go with hypnosis in any form. In reality he is under a moral obligation to acquaint himself with, and use, any accepted form of therapy which will alleviate his patient's problems. He may, however, find it reassuring to know that no one individual has any more than ordinary control over another. A person may be persuaded to do something that he would not ordinarily do, but this is true of the normal as well as it is of the so-called hypnotic state. In the hypnotic trance the subject says in effect: "All right, you have convinced me that I can do what you say I can, and so long as you do not violate my moral code, or place me in personal jeopardy, I will make my mind a blank and let myself respond to the stimuli which you give to my soma." If he chooses he can counteract any suggestion the hypnotist gives to him, and he can wake himself up after we have gone to considerable trouble to put him in the trance. Even in the best of circumstances he chooses to respond to only those suggestions which he considers acceptable, and it is not likely that he ever fully lets the initiative pass to the hypnotist. Heterosuggestion is effective in only four related situations: (1) when the subject voluntarily or inadvertently gives up his ability for volition; (2) when he is willing to echo the thoughts offered by the hypnotist; (3) when he is sleeping, or we have drugged

him into a non-volitional state; (4) or when he is literally caught with his thoughts down.

Previous Techniques for Hypnotic Induction

The literature on hypnosis contains an untold number of hypnotic techniques, but they are merely variations of seven basic approaches. Furthermore, they are very similar in that they all are based upon the production of the so-called trance, the surrender of the subject's capacity for volition, and the use of heterosuggestion. Some of the techniques are no longer used in their original form, others are not of any practical value to the therapist, and none of them are necessary to successful suggestive therapy. It is, however, well for the therapist to understand their principles, because he may then apply them freely when the need arises.

1. Mesmeric Passes:

Anton Mesmer,[15] father of "mesmerism," thought he had discovered a new quality in man and contributed the effects he had on his patients to a "magnetic fluid" which supposedly flowed from his hands to the subject as he passed his hands above the individual in a rhythmic manner. He later transferred his power to inanimate objects, and was able to hypnotize great masses of people in this manner. The modern hypnotist knows that there is no "magnetic fluid" but the passes are still used in many techniques employed by competent therapists. They, however, are still unable to explain why their techniques are successful.

Most of us carry our childhood belief in "magic" and the "supernatural" over into adult life, and this was even more true in Mesmer's day. The incredible belief in "hocus-pocus" makes the subject highly suggestible to any such approach, and since suggestibility is the determining factor in any hypnotic induction, it is not difficult to understand why these efforts are successful. The author has let his imagination run rampant in creating variations of this method, and if we adhere to the principles which have been outlined, there is no doubt about the results. It is a very effective technique for children.

2. Fascination:

James Braid,[4] who coined the word hypnosis, used the fascination method in various forms. The technique requires the subject to focus his eyes and attention upon a fixed, or semi-fixed, object with the idea that his senses will become fatigued and he will go into the hypnotic trance as a result of this. These methods are still used, but they are commonly employed with suggestion. Many therapists, however, condemn these techniques because they produce an over-fatiguing of the eyes which results in eye strain and severe headaches causing the subject to become resistant to further attempts to induce hypnosis.

The objects used by the hypnotist are too numerous to list. They include everything from crystal balls, spinning discs, mirrors, lights, to the simple use of the operator's index finger. Unless the subject has been previously conditioned to respond to one of these objects they have very little direct influence in the production of the trance. Success depends upon the hypnotist's ability to keep the subject's mind occupied with the object so that he is not free to resist the heterosuggestions. It is, simply, another method of placing him in a non-volitional state and, as in all cases, when the subject realizes he is responding to the suggestions of the hypnotist he feels that it is too late for him to resist and willfully submits without a struggle.

3. Domination:

The lord and the peasant were prevalent in Europe during the last century and the majority of the populace were accustomed to being domineered; therefore, it was possible for some of the therapists of that day to dominate their patients in such a way

that it approached the popular concept held by the layman that the individual loses his will.[7] The subject was actually scared into submission, and this is one of the three instances where suggestibility is not necessary. The therapist merely gave his suggestions to a subject who was too frightened to think for himself, and the effect was the same as if he had produced the non-volitional state in a suggestible subject.

If a therapist tried this technique on an American it is not too difficult to understand what the consequences would be. There are, however, certain instances in the modern application of these hypnotic principles where a certain amount of firmness and the domineering spirit is useful. This is very true in the treatment of those individuals who are indecisive in most everything they do. We see it quite often, especially in women who are hypertonic and emotionally unstable.

4. Suggestion:

This technique, which was first introduced by Bernheim,[3] is persuasive by the manner in which it is generally used. The operator uses words to convince the subject that hypnosis is possible, and he uses the same technique in producing the responses. This method is highly respected in medicine because it has none of the theatrics of other techniques, but it requires a great deal of knowledge and skill. If the subject is not already suggestible (i.e., because of the reputation of the therapist, etc.) this state must be produced by a time-consuming period of orientation. In other words, the operator must establish belief, confidence and expectation through persuasion.

The technique is not without its "tricks" and "deceptions," and while the advocates of this method are reluctant to admit this, such acts are quite permissible in the strictest ethical practice. They are not to be condemned any more than many of the deceptions that are used daily in practices of dispensing impotent forms of chemotherapy. The most common form of these deceptions is the use of natural physiological phenomena to convince the subject that he is responding, and the "feed-back" system advocated by Salter.[16]

5. Methods of the Professional:

At one period the professional used "plants" to increase the suggestibility of his legitimate subjects, and many medical authorities claim that this is still a common practice. Leitner,[13] however, denies this and, while I do not condone public exhibitions, I can readily agree with him that there is no need to use "plants." The professional has the advantage over the therapist in that he has a large group from which to select his subjects, and the majority of the audience is already suggestible. The experienced hypnotist merely needs to, and does, conduct preliminary tests for suggestibility before he asks for volunteers and then chooses those who are observed to respond to the tests. He has the further advantage of a brightly lit stage to which the subjects are unaccustomed and the average person momentarily experiences a degree of mental confusion when he is placed before a large audience. A combination of these factors places the individual in an ideal state to receive suggestions, and these "masters of rapid hypnosis" merely take advantage of the situation.

6. Narcosynthesis:

The idea of producing the hypnotic trance with the aid of drugs is found in the literature of the various periods of hypnotic investigation, and Hull[8] in 1930 listed it among the research projects which he recommended. It did not come into vogue, however, until World War II when the psychiatrist became overwhelmed by the number of mental casualties which were left to his care.

This technique is not practical for the general practice of medicine, dentistry, or chiropody, because of the after effects of the various drugs which may be employed, and neither can it be considered to be a normal or ideal manner of obtaining the responses.[12] The subject has lost his ability to resist suggestions, without being in a state of suggestibility, but at the same time we have partially destroyed his ability to respond. Sedation in any form must be reserved for special problems, and it should never be used by the chiropodist, except when he must use the trance. Under such circumstances mild sedation with nembutal, etc., is sometimes helpful in creating a belief in the subject that he is responding.

7. Normal Sleep:

Barber[2] has recently compared the responses of the same individuals in both the sleeping state and the so-called hypnotic trance. His conclusions were that the responses are very similar, and if anything, better in the normal sleeping state.

Sleep is ideal for heterosuggestions, if the subject is receptive to extrasomatic stimuli, because in this state he cannot resist our suggestions. (This completes the three exceptions where suggestibility of the subject is not necessary.) In the sleeping state the subject is not volitive, his capacity to respond is unimpaired, as in narcosis, and he is an automaton to the suggestions of the operator. The only problem is that it is not very practical for the therapist unless the patient is confined to an institution where he will be readily available in the sleeping state.

Discussion:

Before we begin the description of a new technique for inducing the hypnotic responses in the waking subject, it will be well to further clarify what we have said about hypnosis and the mechanics involved in the production of the phenomena. Unless the basic factors involved are clearly understood, no technique can be used with any degree of success.

Christian Science, yoga, faith healers, The Art of Positive Thinking, and all such things are related, and they are the same as hypnosis. All possible human responses are dependent upon previously conditioned reflexes, which are elicited by suggestions when the subject is suggestible, or when he has lost his ability for volition. If a scientist prays for something that is reasonable, such as the relief of pain, his prayers will be answered if he really believes in them. He has accomplished what we might refer to as indirect autosuggestion. If, however, he did not believe that his prayers would be answered he will obtain no relief, because essential elements of suggestibility were not present. Professor Dubois[5] said: "The patient with a functional malady will get well when he is convinced that he will be well; he will be cured at the exact moment he convinces himself that he is cured!" The suggestibility of the individual is the one factor which has been overlooked in the attempts to elicit responses in the direct application of suggestion, and this has led to wrong conclusions. Through a lifetime of conditioning, people approach all new activities doubting their ability to perform, and the majority of their autosuggestions are negative. Their doubt must be changed into belief, confidence, and expectation. A more complicated definition may be evolved around suggestibility, but those three factors are all that is absolutely essential.

Inducing Phenomena in the Waking State

This technique has been used on more than two thousand patients with complete success. Some subjects respond better than others, but this is due to their suggestible state, and there is no doubt that all of them have the same capacity to respond. Individuals who would normally be classified as refractory demonstrate their ability to respond as well, and sometimes better, than

those who would respond to the trance with comparative ease. Patient resistance has been reduced to a minimum, and while there are still minor discrepancies in our approach, this method is reliable and the therapist will find it an improvement over previous techniques.

The manner in which we apply this technique varies with each patient. It permits flexibility, and the approach should be determined by the suggestibility of the subject, the purpose for which it is to be used, and whether or not the end result will be heterosuggestion or autosuggestion. It is, fundamentally, the old method of employing suggestion with the elimination of the trance, and the early responses designed to create a suggestible state in the subject by letting him observe his responses. He finds it easy to believe that he can respond to the simple suggestions and these are pyramided into the other phenomena as his belief and confidence is increased. The early phase of the induction, therefore, serves a dual purpose; it tests his suggestibility and builds it up at the same time.

It will not matter at the beginning whether the operator uses heterosuggestions, or autosuggestions, because the subject tends to become engrossed in his activity as the induction progresses and he willingly relinquishes the initiative and the operator may then do as he wishes. The author always begins with heterosuggestions and proceeds in this manner until it becomes obvious that the patient is resisting. In the majority of cases the subject will respond to all suggestions, but if it becomes apparent that he is not accepting our suggestions we point out the fact that we have no control over him and that he is opposing our suggestions with counter-suggestions. We then let him take the initiative, and when he fails to respond to his own suggestions he can, in most instances, analyze and correct his own mistakes. He must give, or receive, one unopposed thought in order to respond. This is the key to all techniques.

Since these responses are produced in the same way that all responses are elicited it is not necessary, and is ridiculous, to have the subject concentrate. This does nothing more than make him overly aware of what he is doing, and he will invariably revert to the old habit of using negative suggestions. After we have arrived at a diagnosis we simply say: "Mrs. Jones, I think suggestive therapy will help us solve your problem. Do you know anything about suggestion?" While we are saying this we move around to the side of the chair and give her a few seconds to respond to our question. If she admits that she knows nothing about the subject, we say, "That is fine. I find it is much easier to teach my patients how to apply suggestion when they have no preconceived ideas about it." If she claims to know something about it, then, "That is good! You already have the advantage over most of my patients and you will have no trouble in understanding what I am about to teach you." In either case she is made to believe the circumstances are ideal for her to learn suggestion.

No changes in the position of the chair are necessary, and the room is as well lighted as usual and no effort is made to eliminate the other office noises. Treat the whole matter very casually in order to prevent apprehension, and begin the exercises without any further delay.

Remember, the first responses are designed to make the subject more suggestible, and we refer to them as tests. They have no practical therapeutic value and if the subject is already in a suggestible state most of these exercises may be eliminated. We, nevertheless, will now go through the whole process as if we are dealing with the patient who gives us the greatest amount of resistance. It usually takes from ten to twenty minutes to do this.

(1) Floating hand: "Mrs. Jones, hold your hand as I am holding mine." (The arm is extended with the palmar surface up, the elbow bent at a forty-five degree angle and the hand hanging limply at the wrist.) "I am now going to suggest to you that the hand will become light, and you will observe how it responds. You don't have to concentrate or do anything except feel the sensation of lightness. Your hand knows exactly what I want it to do and it will carry out my wishes all by itself." Insist on the subject keeping his hand in that position until the proper sensation is felt. Gravity will drain the blood from the hand and if the patient has not responded immediately, as he should, this will cause him to believe that he has responded—and this is very important. If the patient is not sure that he is experiencing the proper sensation, use his own words to assure him that he is experiencing exactly what you wanted him to feel. If he appears to be failing the test completely go on to another with the explanation that we are all different and that it is not necessary for him to produce all the responses. Assure him that he will experience most of the sensations. If you persist in the matter too long the subject will build up a "mental block" and will then question his ability to respond to all other tests. Most subjects will respond properly to all suggestions without any deception, but if they fail a few this is not important. You may come back to these when the subject is more suggestible and it is most likely he will respond adequately.

(2) Progressive weights: "Mrs. Jones, extend your arm straight out in front of you. You know from experience that you could probably hold your arm in this position for at least five minutes without getting too tired. I am, however, going to suggest that you are holding a weight in your hand—you won't feel the object, but the muscles in your arm will get tired just as if you were holding a real object." Her arm is getting tired while I am talking, but she has been distracted and will not observe this until I focus her attention upon it. If the patient gives a good response to the first test it is likely that he will also respond to the others, and since you want him to respond properly, don't use "trickery" except when it is necessary. If he does not give the desired response to the first test then keep him distracted on the second until you are certain the arm should be tired enough for him to suddenly feel it. "You probably feel your arm responding because I have already planted the suggestion." Encourage the subject to admit that he is feeling the sensation. "Now, as I touch your hand with my finger your arm will feel as if I am placing books upon it and the weight will get increasingly heavy. When the load becomes too heavy for your arm it will drop by your side." When this happens then point out the fact that the arm feels tired as if it had really been supporting books, "But you have been deceiving your arm and it really didn't do any work, so suggest that it is not tired and the sensation will immediately disappear." It always does, but if you are uncertain about this go on quickly to the next test.

(3) Hand fixation: "Have you ever stopped to consider how we go about raising and lowering our arms? We do it hundreds of times each day, and it sometimes seems as if our body behaves by itself, but the truth of the matter is we have to give a thought for each movement. I'm going to demonstrate how this works, so just let your arm rest comfortably on the chair. I'm now going to suggest that you cannot raise your right arm, and it will feel heavy and you will not be able to move it." This may be one of those instances where they think to themselves: "The heck I can't!" This will be obvious by their ability to raise the arm. Don't be alarmed by this

resistance, just prepare to continue with autosuggestion, and say: "There is no doubt in my mind that you can raise your arm when you want to, but if you want it to stay fixed against the chair then you must use a suggestion to that effect. You cannot go uphill and downhill at the same time. You are giving yourself opposing suggestions at the same time and your body will not respond under such circumstances. It is the same as if you turned on a motor and quickly turned it off." If they fail again, "You still haven't gotten rid of that little voice which keeps saying, 'Oh, yes I can'!" Again, learning to give one thought at the time is the key to the whole phenomenon.

The hand and arm is also fixed above the patient's head. "You would think gravity would make your arm fall, but you will notice that it feels as if something is holding it there." Many of our patients have reported that they often go to sleep reading with their arms fixed in rigid positions and if the spouse tries to straighten it out it wakes them up.

(4) Eye fixation: We usually begin with this test when the patient appears to already be suggestible. Have the patient close his eyes and suggest that he will be unable to open them. "Now, Mrs. Jones, you will be unable to open your eyes, in the same way you were unable to lift your arm. You can try to open them, but the most you can do will be to raise your eyebrows. The harder you try to open the eyes the harder the lids will seem to be stuck together." If the therapist will have the subject roll his eyes upward with the lids closed it will be physiologically impossible for him to open his eyes, and this can be used when necessary.

(5) Arm-levitation: "We will now do a test which fascinates most people. Place your hand on the arm of the chair and let it relax. Now, your hand and arm will slowly begin to feel light and then the hand will float off the chair just like a balloon. I will place my hand here as a goal. Of course, it is a normal reflex action, but it will feel as if you have no control over the arm and hand." The therapist will observe that the hand will behave just as he suggests that it will. If the subject is told that the fingers will twitch, and that the hand will throb as it gets light they will do this. The patient will also experience Mesmer's "magnetism" if this is suggested to him.

(6) Pain and Anesthesia: These phenomena are produced so easily that we often use them as "tests" to increase the suggestible state. Some degree of anesthesia can be produced instantaneously by merely designating the area involved. Pain, like the arm-levitation, takes two or three minutes in adults, but it is also instantaneous in children.

If anesthesia is produced for a practical purpose the therapist must remember that his patient is fully aware of his ability to think, and he has been conditioned to experience pain when there is trauma. He often finds it difficult to believe that the anesthesia will stop the pain of a knife wound, and he removes the anesthesia as easily as he produced it because of this lack of confidence. If he has any doubt it is best to begin by inflicting small amounts of trauma and gradually increase this until it approximates the pain which he thinks the knife would produce. This takes very little time, and once he sees a knife piercing his flesh without any evidence of pain, he is as suggestible as he will ever need to be. From then on he knows he can produce a complete state of anesthesia and he does this with complete indifference.

If the therapist produces anesthesia he must always remember to remove it, and if he has used autosuggestion it is wise to warn the patient against removing pains of unknown origin. This is the only con-

ceivable way in which any harmful effects can result from the use of suggestion in chiropody.

(7) Others: There are several other "tests" that may be used, such as the handlock, itching nose, etc., but for all intents and purposes, the subject is now capable of producing any of the so-called hypnotic responses. His first efforts are not always satisfactory, but once he has responded to a suggestion he has full confidence in his ability to respond again. He always produces a response a second and third time with greater ease, and with a greater degree of perfection.

Summary

1. Hypnosis does not exist as a separate entity, and the trance is not a necessary part of any hypnotic technique.

2. The phenomena result from previously conditioned reflexes which are stimulated by a process which we may continue to call suggestions, and this is dependent upon the patient's suggestible state, or his ability to resist heterosuggestions. Suggestibility is the result of the subject's belief, confidence and expectation.

3. All seven basic induction techniques which have been used previously are dependent upon the creation of the so-called trance, a lack of volition on the part of the subject, and heterosuggestion.

4. A new technique was outlined in which all the phenomena may be obtained in the waking subject while he retains the ability to think clearly. The responses may be elicited by either heterosuggestion or autosuggestion.

5. The new technique is suitable for chiropody and the patient accepts it without resistance. It is also suggested that the chiropodist add suggestive therapy to his armamentarium.

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Errata:

Inadvertently the following final paragraph of Dr. Locke's paper (January 1958, p. 17) was omitted: "The author wishes to acknowledge the assistance of Sidney Zislin, D.S.C., Palmyra, N. J. in the preparation of this paper."

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

INTRA-ARTICULAR HYDROCORTISONE IN CHIROPODY

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Articular and bursal lesions of the foot are of frequent occurrence and, with few exceptions, are difficult and tedious to treat. In my experience, the results of treatment by injection of hydrocortisone are speedy and effective. Hydrocortisone is an adrenocortico-steroid which is antiphlogistic in nature, for it reduces inflammation and the inflammatory potential of connective tissue. When injected into an inflammed joint, such as an acute hallux rigidus, it not only reduces the inflammation, pain and swelling, but also conditions the structures of that joint for a time to further stresses of locomotion. When injection is made into a bursa or into a joint space the effect is entirely local, with no systemic effects.

Whenever joints and bursae are affected by mechanical stress or by disease, hydrocortisone therapy may be used alone, or in conjunction with the usual chiropodal paddings and strappings. The technique used is of prime importance. Many of the failures reported undoubtedly are due to failure of the operator to inject into the joint or bursa.

The conditions treated routinely by hydrocortisone arthrocentesis are hallux rigidus, periarticular fibrositis, acute traumatic arthritis, retrocalcaneal bursitis, tenosynovitis, and osteoarthrosis and rheumatoid arthritis. In acute hallux rigidus this therapy has a dramatic effect. The joint should be palpated to find the point of greatest accessibility; this usually will be around the medial dorsal aspect of the joint margin. After cleansing the area, and intradermal injection of a few drops of an anesthetic, a needle on a dry syringe is inserted into the joint. The joint is aspirated and excess synovial fluid removed. The syringe is removed without disturbing the needle, and a tuberculin syringe attached, containing 0.3 to 0.5 cc. of hydrocortisone, which is then injected. In most cases entire relief of pain and swelling and increase in motion will be noted within 24 hours. The relief will last from two weeks to several months. The usual chiropodal follow-up is of great value.

We have all seen patients who have a history of chronic pain in a metatarsal-phalangeal articulation, most commonly the second or third. We find that, because of faulty foot structure or function, this joint has been subjected to constant minor trauma, produced by excessive weight transmitted beyond the normal structural capacity of the joint. Frequently there is an indurated mass palpable just below the joint. The disorder is variously termed periarticular fibrositis, periarthritis, or chronic traumatic arthritis. Conventional paddings and strappings are effective, but tedious to apply, and results are slow. An injection of 0.3 cc. hydrocortisone will effect surprising results within 24 hours. Injection is made dorsally, slightly to the medial or lateral side to avoid the dorsal tendon. Holding the toe in slight plantar flexion will facilitate the injection. Occasionally the toe is injected 24 hours pre-

*Presented at Annual Meeting, National Association of Chiropodists, Chicago, Ill., August, 1957

viously with xylocaine and manipulated to break up adhesions when this seems judicious.

An injection of hydrocortisone into acutely traumatized joints, either metatarsal-phalangeal or others in the foot or ankle, will bring almost immediate relief and comfort. Hydrocortisone used alone is effective in retrocalcaneal bursitis if no sepsis is present. However, in several cases where asperation had been done and cultures made, active bacterial infection has been found to be present. I prefer to use injections of Neo-Cortef®[1] for heel bursae — a combination of neomycin and hydrocortisone. Hydrocortisone has proved to be a valuable adjunct in treatment of any inflamed adventitious bursa appearing on the foot, such as is seen over a hallux valgus.

Many rheumatoid arthritics are subject to frequent exacerbations in the foot. Usually these occur around the talonavicular articulation and in the ankle. Rarely do they respond to oral medication. Hydrocortisone or prednisolone by injection gives almost immediate relief. However, if the patient is receiving systemic medication, these drugs should be given only after consulting with the patient's physician, in order not to conflict with his course of treatment. In osteoarthritis the relief obtained and the duration of relief are variable; consistent good results cannot be expected in all patients. However, with paddings and strappings to aid in control of this condition, the drug is of some value. When injected into an osteoarthritic ankle, hydrocortisone will lessen the stiffness, increase the range of motion, and lessen the pain of walking, in varying degrees in individual patients. Repeated injections will usually be required. In my experience no anatomical change, such as disappearance of osteophytes, has been demonstrated, but others have occasionally reported such a change.

Although there is no true articulation at the site of a calcaneal exostosis, many operators have reported excellent results following injection of 0.5 to 1.5 cc. of hydrocortisone into the area. Some assert that a bursa is present which is thereby affected. In my practice this procedure has been attempted in only six patients and the benefit derived from the injections has not seemed to justify their use.

Since the resultant action of the steroid is purely of a local anti-inflammatory nature, the only formidable contraindication would be the existence of active infection by microorganisms in the region. From 10 to 15 per cent of the patients treated by this method experience a local reaction to the drug. This reaction consists of mild to intense pain, rubor, and edema in the area treated, but appears to have no effect on the end result. Since using prednisolone (Meticortelone)®[2] no such reactions have been noted.

The advantages of this method are considerable in conditions such as periarticular fibrositis, tenosynovitis, and bursitis in which the lesion is confined to a definite circumscribed area; this area can be treated directly. Where one or more joints are affected by disease, they may be treated individually and effectively without causing systemic involvement. Where the antiphlogistic action of cortisone or hydrocortisone is undesirable because of a disease which contraindicates its oral use, such as heart disease, peptic ulcer and tuberculosis, absence of systemic effect is important.

Summary

Intra-articular hydrocortisone injections have been found to be of value in a wide variety of foot conditions. It has proved of particular value in treatment of hallux

®[1] Neo-Cortef—Upjohn

®[2] Meticortelone—Schering

rigidus, acute traumatic arthritis, adventitious bursitis and periarticular fibrositis.

In osteoarthritis, rheumatoid arthritis and retrocalcaneal bursitis some patients have received great benefit, while others have responded to a limited degree.

In the treatment of calcaneal exostosis and Morton's neuralgia the drug has proved of little or no benefit.

Intra-articular injections of hydrocortisone do not prove a panacea for all foot conditions, but if used properly in the diseases indicated, this therapy will succeed in a very high percentage of cases.

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A METHOD OF TREATMENT FOR DIFFICULT VARICOSE LEG ULCERS AND POOR CIRCULATION OF THE LOWER EXREMITY*

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Leg ulcers of varicose origin are caused by the gradual breakdown of skin and tissues due to faulty circulation. When the valves of the veins fail to function properly, it is usually due to an illness, injury, or hereditary tendency. The blood then remains stagnant instead of returning to the heart. This stagnation can produce any one of several conditions which can ultimately lead to the formation of an ulcer or ulcers.

In conjunction with this conditon there is a loss of skin tone and the area becomes an ideal, susceptible environment for infection. The leg will often become edematous, a condition known as lymphedema. Now with the advent of an infection or an injury which would cause a skin lesion, the area becomes progressively worse. Finally, there appears an ulcer with all its attending problems, a nasty site which weeps and possibly bleeds, very often is exquisitely tender to touch and tends to persist.

A persistent venous stasis in the lower extremity or chronic lymphedema is a potential source of trouble. Increased extracellular fluids of an excess protein nature tend to induce the development of a fibrosis which is also an ideal environment for infections of the skin. Skin pigmentation and subcutaneous tissue induration eventually develop. Again we may finally see the symptoms of inflammation in phlebitis, chronic cellulitis or dermatitis with staphylococcic or streptococcic contamination. These are all latter stages from the effects of venous stasis and lymphedema.

With the presence of recognizable varicosities or when enlarged veins are readily felt, many tests for the failure or incompetence of the communicating veins are available. Two basic tests are usually sufficient. (1) The Trendelenburg Test: compression of the main saphenous vessels and the rapid filling of the emptied channels below a tourniquet, on standing. (2) Ochsner-Mahorner Test: emptying of the full veins on walking. When induration of skin and underlying tissues has occurred, the affected veins often are not always visible in the underlying surface, nor sometimes palpable; therefore, the clinical tests become inadequate. Under these conditions, comparative measurements of volumetric

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changes in the legs with change in position has proved useful in determining incompetency of the perforating veins.

A major factor to consider is the measurements taken in both the recumbent and standing positions, also with and without a tourniquet in the latter position. With this technique in the testing of normal lower extremities, differences in measurement increases vary from approximately two to five inches. Evidence of differences over five inches when standing with a tourniquet, is indicative of venous stasis. In patients with excessive changes in measurement, definite incompetency of perforating veins is to be noted. Care should be taken to observe any condition which might disguise these measurement differences in postural changes: acute inflammatory swelling or an acute thrombosis which may be temporarily obstructing some of the perforators.

With regard to the treatment of venous stasis, when the failure of proper valve function is in the greater or lesser saphenous veins the upper division of the main channels will often suffice to correct the condition. If the failure is in large due to incompetency of the communicating veins then correction of venous stasis becomes increasingly difficult. On the removal of the superficial veins we may have dilation of the communicating veins into incompetent channels causing a recurrence or venous stasis which is, again, a problem.

Many physical appliances are used to control venous stasis and a great many are fairly successful. In most types the basic principle is the use of elastic tension such as elastic hose or bandage, or the use of a non-elastic material to prevent further expansion, such as Unna paste boot.

In creating a more practical method for treating the above, we propose a new method. This new method or appliance is extremely desirable because, when worn, it allows the underlying tissues to be exposed to a pulsating pressure during activity of the limb in a manner similar to the effect of muscular contraction on the deep veins. It is as if an additional deep fascia had been placed around the leg causing the subcutaneous veins and lymphatic spaces to be compressed rhythmically when walking. The posterior muscles contract and expand under the appliance, causing a milking effect upon the leg, tending to expel excessive extracellular fluid. With this basic premise, exercise by the involved patient would no longer be contraindicated. Sufficient tension should be maintained by this method so as to yield the equivalent of approximately fifty-five millimeters of mercury pressure.

The use of medications no longer is a hindrance since the appliance can easily be removed or replaced. Medications can be applied readily to any ulcerated area.

Extra pressure can also be maintained by

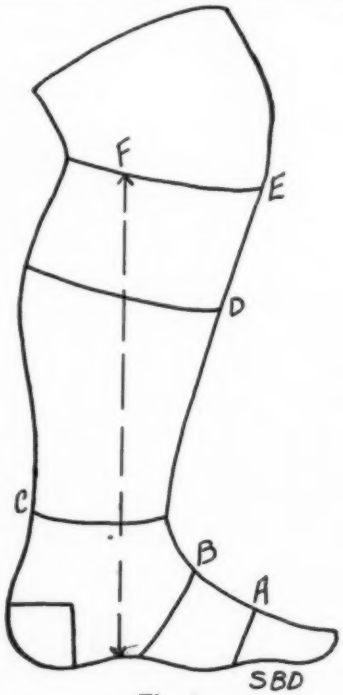

Fig. 1

increasing the plastic foam thickness over a specific site. If the area is sensitive, one can first apply an underdressing of Webril ®[1] or some similar material to prevent even the mildest friction.

To construct the appliance we make use of an elastic hose which is ordered from the measurements shown in Fig. 1. as follows: A—circumference proximal to the toes, B—circumference of the instep, C—circumference at narrow portion of ankle above the malleolus, D—circumference at widest portion of calf, E—circumference at narrowest portion above calf and below knee, and F—the desired lengths of hose. The appliance may be constructed of cotton, nylon, rayon, or combinations of these. The hose is slit in its length either medially or laterally and a side zipper is inserted. This would be placed on the side where there is the least amount of difficulty. The entire hose, with the exception of the instep, is then lined with a plastic foam material. This material is more desirable than foam rubber (which can also be used) for it is very fine in consistency and allows for evenness in construction. The foam plastic or foam rubber should be 3/16 to 1/4" thick. The covering of the heel is optional depending on whether it is needed or not, as is the question of whether the foot portion is needed. This method is comparatively inexpensive and easy to apply.

Summary

A new approach in the management of varicose ulcers and venous stasis. It is easy to apply and maintain. With it, walking may now be advised. Medications may be continued in conjunction with this appliance.

21 South 69th Street

®[1] Bauer & Black.

CLINICAL USE OF A NEWER TYPE LOCAL ANESTHETIC

MARVIN J. SOFFER, D.S.C.*

Gloucester, N. J.

Chloroprocaine hcl®[1] is a recently developed local anesthetic found to be ideal for nerve block and local infiltration in clinical use. It is the first local anesthetic more potent, yet less toxic, than procaine. In equal percentage strengths and volumes, its potency is twice that of procaine and its toxicity half. It has a very rapid onset and a greater intensity compared to procaine or lidocaine hcl and it penetrates the tissues readily without the addition of hyaluronidase in infiltration procedures.

According to the original research[1], chloroprocaine hcl is hydrolyzed in the blood four to five times as rapidly as procaine and because of this, does not accumulate in the blood as readily. Therefore, it has less tendency to toxicity unless large doses are rapidly injected intravenously[2]. Chloroprocaine can be mixed with Adrenalin in small concentrations of 1 to 200,000, but in chiropodical practice this has not been found to be necessary or advantageous.

In surgical correction of helomata and excision of ingrown toenails, 2½ cc's of 2% solution suffices for nerve block of the big toe and 1-1½ cc's for the lesser toes without the addition of a vasoconstrictor. When injected for Morton's neuralgia, 2-3 cc's will produce good results. The 2% solution is of greater practical value than the lesser concentrations.

103 N. Broadway

References

1. Foldes, F. F., and Aven, M. H.: Journal of Pharmacology and Exp. Therapy, 105; 259, 1952.
2. Foldes, F. F., and McNall, P. G.: Anesthesiology 13; 287, 1952.

* Staff, Audubon Hospital, Audubon, N. J.

®[1] Nesacaine HCL, Maltbie Laboratories Division, Wallace & Tiernan, Inc., Belleville 9, N. J.

JOURNAL

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A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

PRESIDENT'S MESSAGE

The American Podiatry Association is, in a sense, a new organization, as well as being a new label. We are constantly reminded, however, that we are superimposed upon the solid bedrock of the National Association of Chiropodists as it was conceived by the founder and developed by our patron saint, Dr. William J. Stickel. Each day as I am called upon to administer our affairs, the wisdom and substance of his tenure becomes more apparent.

We are new in the sense that we have come of age. We have, at long last, begun to define our objectives and even more than that, have engaged ourselves to the task of actively pursuing the necessary programs for the accomplishment of these objectives. Your national organization has established a format which will develop our schools through an aid to podiatry education program; has a medical relations program; will provide each state with an advisory on Blue Shield status; and finally, is accelerating the development of our national headquarters into a vigorous and effective voice for the continuous progress of our profession.

The American Podiatry Association is only as strong and as vigorous as the state societies themselves. The strength of our profession does not filter down from the top but rather does it reflect that strength to be found at the grass roots. How well we shall succeed in achieving our aims will depend primarily upon the enthusiasm of the officers and members of the various state societies. All of the programs in which we are now actively engaged are dependent for their ultimate success on the ability of the states themselves to unite in the pursuit of these common objectives and the ability of the state officers to solicit successfully the aggressive participation of each member. It can clearly be seen that only through such unity can we accomplish our goals.

Consequently our progressive organizational growth and development is almost wholly dependent upon the growth and development of our affiliated state societies. As with every professional group, we too are frequently limited by the presence of splinter groups. Let us recognize that these tend to reduce

our total effectiveness. Each state society is urged to pursue vigorously, negotiations that would ultimately bring about the inclusion of these less informed people, so that they too may be educated to our level of aspiration and may, in turn, share the benefits of our combined efforts.

Our success grows more apparent each day. We have a great deal to offer. Let us be generous and share the fruits of our many accomplishments with all who practice our profession, in the interest of the public welfare.

JONAS C. MORRIS, D.S.C.

PROTECTING THE PUBLIC IS OUR RESPONSIBILITY

One of the William J. Stickel Award papers, presented at the August 1957 meeting, was a scholarly paper by Milton Henenfeld, describing the dangers of casting for custom shoemaking.

About the same time, an article by M. D. Roven, sponsored by the Foot Health Information Committee of the New York State Podiatry Society, discussing a similar topic with the average lay foot sufferer, was published in the Flatbush Magazine.

At the 1957 House of Delegates, this problem was recognized officially by including in our general policy a statement that we, "dedicated to the public interest, [are] desirous of seeing that impressions for appliances, shoes or any therapeutic devices, should be the sole responsibility of licensed members of the healing arts." (Resolution 41-c).

As the only profession in the healing arts whose principal interest is the foot health of the nation, it is our responsibility that the public be protected from possible harmful effects by the efforts of untrained people. The National organization has adopted a stand on this and it now becomes a duty of each state society to implement this. Several states have been able to incorporate such protection for the public in professional practice acts. In many states, it may be possible to obtain the same protection by rulings from some state agencies. Perhaps an education program will suffice.

One individual harmed through injudicious efforts of untrained personnel, is a reflection on our capacity to safeguard the foot health of the people of our state.

NON-AFFILIATED ORGANIZATIONS

There are a number of independent organizations who are devoting themselves to the advancement and dissemination of knowledge in our profession. One of the prerequisites for membership in these organizations is membership in our national association. The Council on Scientific Sections is working on a program to see if these cannot be formed into one organization and thus extend their good work.

It will perhaps be possible for this new amalgamated organization to affiliate with the A.P.A. Until this becomes possible, or is accomplished, we should like to have the name, officers and a copy of the constitution and by-laws of these organizations. Some of them have copies on file in the national office. We would appreciate receiving similar information from all organizations not presently affiliated with the National.

WASHINGTON REPORT

Congress Resumes

The second session of the 85th Congress convened in accordance with the resolution adopted before adjournment of the first session, at noon on Tuesday, January 7. All of the Senators, but six, answered to roll call, three of whom were reported ill. After certain necessary routine business was disposed of, adjournment was taken to noon, Thursday, January 9th when, together with the House, they met to hear the President deliver his State of the Union message.

The House also convened on Tuesday, January 7th. The Speaker announced the resignation of two members of the House and the deaths of two of its most distinguished members, Honorable Jere Cooper of Tennessee and Honorable Henderson Lanham of Georgia. Mr. Cooper was Chairman of the very important Ways and Means Committee and Mr. Lanham was a member of the Appropriations Committee. Before adjourning, the House elected Honorable Wilbur D. Mills of Arkansas to succeed Mr. Cooper as Chairman of the Committee on Ways and Means.

Many members took the occasion to express their deep sorrow over the sudden death of these two prominent men.

Congress, returning prepared to pick up the measures it left incomplete when it adjourned in the summer, finds itself faced with a series of problems on defense that demand priority over important conditions incident to welfare and education. The immediate demand upon Congress is to increase scientific research. More young people must be interested in the basic sciences and more schools and colleges must be provided for their instruction. The Secretary of H.E.W., Marion Folsom, announced that college enrollments set a new record so far this year and will materially increase with the opening of the second semester. A total of 3,068,000 students enrolled in 1,890 institutions early last fall, an increase of 4.1% over the fall of 1956. College enrollment since 1951 has increased 45%, while the number of young persons between the ages of 18 and 21 years, increased by 2%. He said that about 1,100 colleges and universities have been invited to participate in a tally of college juniors majoring in sciences and mathematics. The survey should help educators deal with the problem of dropouts of science students.

The survey is expected to give educators a two year lead in the knowledge of potential supply of scientists and mathematicians. The questionnaire covers such general physical sciences as astronomy, chemistry, meteorology, physics, geology, etc. The biological sciences include general biology, botany, zoology, bacteriology, etc.

A General Research Training Grants Program to be financed through the National Institute of Health, is being inaugurated to provide aid for graduate level training in medical schools, universities and other qualified training institutions. Additional trained research personnel is badly needed, the Department of H.E.W. states. This new program extends and supplements, but does not replace the research training opportunities available through our regular research fellowship awards to promising individuals. Institutions receiving funds under the new program will elect and appoint individuals for pre-doctoral and post-doctoral training.

Late in December, the Public Health Service announced the award of forty 5-year fellowships to scientists in thirty-four universities and schools of medicine, dentistry and public health in twenty-one states and the District of Columbia. The recipients were recommended by their respective installations. All have doctor's degrees in medicine or one of the health related sciences. The program was initiated last

year with the award of forty-four fellowships and will be continued until approximately two hundred and fifty have been given.

Communicable Diseases

Asian Influenza is subsiding more rapidly than it did in other countries, probably due to our use of the vaccine. Since September 1st, a total of between fifteen and twenty million cases of Asian Influenza is estimated to have occurred in the United States. Outbreaks have been specifically reported by more than 50% of the counties in the nation. Dr. Burney, Surgeon General, Public Health Service, warns, however, that further outbreaks are possible. The disease can be expected to occur throughout January, February and March, when influenza is usually at its peak.

In general, communicable diseases continued their steady decline. The death rate from tuberculosis has gone down from 36.4 per hundred thousand in population in 1946, to an estimated 7.7 for the first nine months of 1957. There was an 84% reduction in paralytic poliomyelitis compared with two years ago. Heart disease and cancer continue to account for 70% of all deaths.

Congress is expected to continue its strong financial support of the department's program for medical research and training of research scientists. One hundred and ten million dollars was allocated for grants to states and for research by laboratories, medical schools, universities, hospitals and individual scientists throughout the nation.

Social Security

The administration will open twenty-five new district offices throughout the country in the next three months, H.E.W. announces. Many of the new offices will be in agricultural areas so that the farming population, only recently covered by Social Security Law, will have the services of the district office without having to travel long distances. There are 558 district offices now in operation and the new offices will bring the total to 583.

Nearly eleven million persons now receive Social Security payments each month. The earnings of approximately seventy-five million people are reported for Social Security credits every year. Benefit payments from the Old Age Security Insurance Trust Fund increased from 5.7 billion in 1956 to 7.3 billion in 1957. This record increase was largely the result of benefit payments to about 350,000 persons with self-employment income from farming and to about 650,000 women between the ages of sixty-two and sixty-five.

Let us remind you that for several months we have been urging the members to call upon their individual congressmen and explain to them that H.R. 6874, introduced by Mr. Harris of Arkansas and H.R. 6875, a companion bill introduced by Mr. Wolverton of New Jersey, provide for Federal grants for improvement of medical and dental teaching facilities. Schools of podiatry-chiropody are not mentioned. There is also H.R. 9467 by Mr. Forand of Rhode Island. This bill is characterized by the American Medical Association as socialized medicine and they are opposing its enactment. For these several reasons, we urge again that you write to your congressman, asking for his assistance.

SCIENTIFIC EXHIBITS

All individuals and organizations who plan a scientific exhibit for our annual meeting should get in touch immediately with Dr. L. C. Numbers, Chairman, Scientific Exhibits Committee, 1327 N. Clark St., Chicago, Ill., or Dr. Edward Ganny, Co-Chairman, 1801 K St., N.W., Washington, D. C.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Achrocort

Description: Antibiotic, topical. Each Gm. contains 30 mg. of tetracycline hydrochloride and 10 mg. of hydrocortisone acetate in a water-washable cream base.

Action and Uses: A wide range of gram-positive and gram-negative organisms which cause skin infections are known to respond to tetracycline therapy. The addition of hydrocortisone reduces inflammation and aids in the healing of affected tissues. Effective in allergic and contact dermatitis, food and infantile eczema, and other skin disorders in which both anti-inflammatory action and prevention of infection are desired.

Administration: Topically as needed.

Supply: Achrocort Cream in 5 Gm. tubes, by Lederle Laboratories Division, American Cyanamid Company, Pearl River, New York.

Typical Prescription

Rx Achrocort Cream 5 Gm.

Disp. No. 1 Tube

Sig: Apply b.i.d.

Bacitracin-Neomycin Ointment

Description: Antibiotic, topical. Each Gm. contains Bacitracin 500 units. Neomycin sulfate 5 mg., (equivalent to 3.5 mg. Neomycin base).

Action and Uses: This antibotic combination, because it is virtually non-toxic, non-irritating and non-allergenic, may be used topically for the treatment of superficial skin lesions with little danger of sensitization. Such infections include impetigo contagiosa, impetiginized dermatitis, ecthyma, pustular folliculitis, decubitus ulcer, also useful as an adjunct treatment of paronychia, and furunculosis and in treating secondary infections.

Administration: Topically.

Supply: Bacitracin-Neomycin Ointment in tubes of ½ ounce and 1 ounce, by Abbott Laboratories, North Chicago, Ill.

Typical Prescription

Rx Ung. Bacitracin-Neomycin 30 Gm. (Abbott)

Disp. Tube No. 1

Sig: Apply twice daily.

Cinbisal

Description: Each engestic coated green tablet contains Colchicine 250 mcg. (1/250 gr.), Sodium Salicylate 300 mg. (5 gr.), Ascorbic Acid 15 mg.

Action: Antirheumatic, analgesic and uricosuric. Both Colchicine and sodium salicylate are recognized as effective agents in gout and gouty arthritis. While Colchicine has a specific effect, its mode of action is unexplained. Sodium salicylate, as well as being analgesic, promotes the excretion of uric acid. Both agents have been shown to stimulate the anterior pituitary and releases adrenal cortical hormones.

Advantages sighted by McNeil: Dual action Cinbisal provides two effective agents long recognized as specific in the treatment of gout and gouty arthritis. The combination can be used for both the acute and the "interval treatment."

Low toxicity—it has been used continuously (for as long as 5 years) during "interval treatment." The ascorbic acid will replace the vitamin C which may be lost

in urinary excretion as the result of salicylate intake. "Under stress conditions, the adrenal cortex rapidly becomes depleted of its ascorbic acid. Therefore, it is desirable to maintain adequate body stores of ascorbic acid at all times." The special engestic coating reduces the nausea and digestive upsets occasionally associated with salicylate therapy.

Dosage should be stopped or modified if diarrhea, nausea or vomiting appears. These gastrointestinal disturbances are the only side effects to be anticipated in therapeutic doses.

Indications: Useful in the management of rheumatic disorders, particularly gouty and rheumatoid arthritis, including associated myositis, fibrositis and bursitis.

Dosage: Acute cases, 2 tablets every hour until pain is relieved. Eight or ten doses usually suffice. To prevent recurring attacks, two to six tablets daily in divided doses, as indicated.

Supply: In bottles of 100 and 1000 by McNeil Laboratories, Inc., Philadelphia, Pennsylvania.

Typical Prescription

Cinbisal Tabs.

Disp. No. 100

Sig: Two tabs. t.i.d.

Darvon Compound and Darvon

Description: Darvon is a new non-narcotic analgesic discovered and synthesized in the Lilly Research Laboratories and is chemically different from other analgesics. Darvon is equal to codeine in intensity and duration of action. The above information according to available literature.

Indications: Darvon is indicated for the reduction or amelioration of all types of pain, particularly those associated with chronic or recurrent disease. Darvon Compound, a combination of Darvon with 'A.S.A. Comp.' (Acetylsalicylic Acid and Acetophenetidin Compound), provides antipyretic and anti-inflammatory activity as well as greater total analgesic effect.

Darvon Compound is indicated for the relief of pain associated with such conditions as: premenstrual cramps, muscular pains, arthritis, neoplastic diseases, headaches, bursitis, traumatic pains, vascular disease.

Side Effects: Nausea, vomiting and other gastro-intestinal disturbances, frequently observed with codeine, are minimal with Darvon. Therefore, large doses of Darvon may be successfully administered.

Dosage: Darvon alone: 32 mg. every 4 hours or 65 mg. every 6 hours as needed for pain. Darvon Compound: One (1) or two (2) pulvules every 6 hours as needed for pain.

Supply: Darvon Compound (No. 368) in bottles of 100. Darvon—32 mg. (No. 364) in bottles of 100. Darvon—65 mg. (No. 365) in bottles of 100. Eli Lilly and Company, Indianapolis 6, Indiana.

Typical Prescriptions:

Rx Pulvules Darvon 32 mg.
(Lilly)
Disp. No. XXIV
Sig: One every 4 hours

———

Pulvules Darvon 65 mg.
Disp. No. XII
Sig: One every 6 hours

———

Pulvules Darvon Compound
Disp. No. XXIV
Sig: One or two every 6 hours as needed for pain.

CORRECTION

Under "Convulsive Reaction" in the article "Emergencies in Your Office and What To Do" appearing in the December issue (page 627), the following correction should be made: " . . . premedication with Pembules of Sedadex" should read " . . . premedication with Pembules or Sedadex."

TECHNIQUES IN FOOT SURGERY

L. R. McCAIN, D.S.C., F.A.C.F.S., and N. H. KETAI, D.S.C., F.A.C.F.S.
Editors, Publications Committee, A.C.F.S.

Illustrated case reports and discussions, suggesting approaches to podiatric surgery, from the files of the American College of Foot Surgeons.

SURGICAL REMOVAL OF FOREIGN OBJECT (NEEDLE) FROM FOOT

A white man, aged 42, seen in the office, complained of the great toe on the right foot feeling cold, especially when the temperature was below approximately seventy degrees.

Roentgenogram revealed one-half of a needle which was broken into three pieces lying along the medial plantar aspect of the proximal phalanx of the great toe. Further questioning of the patient indicated that approximately seventeen years previously he had run a needle into the toe but thought it had all been removed at that time.

Urinalysis was negative for sugar. Blood count findings were as follows: R.B.C. 5,400,000, W.B.C. 8,500, Hemoglobin 98%.

After sterile technic, anesthesia to the toe was effected by the use of three cc. of Xylocaine Hcl.® 2%. The following procedure was used: A lineal incision approximately 2½ cm. long was made on the medial plantar aspect of the proximal phalanx of the great toe of the right foot. Blunt dissection was used to expose a fibrotic mass which was removed. The broken needle was enclosed in this mass. The incision was closed with seven 000 dermal sutures. Telfa®[2] was placed over the wound and pressure dressing was applied after putting Achromycin Hcl.®[3] into the wound.

The patient was given six one-half grain Empirin Compound®[4] with Codeine Phosphate tablets to be taken at three hour intervals if pain persisted.

Postoperative treatment was as follows: On the second day following surgery the outer dressing was removed and sterile dry gauze dressing applied. This same treatment was used on the fourth postoperative day. Sutures were removed on the seventh day following surgery, and sterile redressing made. On the tenth postoperative day a cocoon dressing was applied and the patient was dismissed on the fourteenth day.

Comments: This is an example of one of the interesting surgery cases seen in the podiatrist's office.

L.R.M. & N.H.K.

®[1] Astra
®[2] Bauer & Black
®[3] Lederle
®[4] Burroughs Wellcome & Co.

"THE educated man must study mankind. He does this first by studying himself. He learns his own strength and limitations, and then he develops a sensitivity, an awareness, to the impact he has on the lives of others."

Clarence B. Randall
Chairman of the Board,
Inland Steel Company

ABSTRACTS FROM THE CHIROPODY LITERATURE

ROBERT SHOR, D.S.C.
LOS ANGELES, CALIF.
Chairman, Committee on Publications

Editors of Local, State and Regional Publications are requested to provide copies to the Chairman of the A.P.A. Committee on Publications who is preparing this section of the Journal.

A NAIL GROOVE PACKING TECHNIQUE

Robert Tanner, Footprints — Fla. Chir. Ass'n., 2:2, Sept. 1957.

Tanner presents a simple and effective treatment of inverted nail conditions. The technique is as follows: 1. Paint area with Tincture of Merthiolate. 2. Cut a small piece of foam rubber, inserting the piece both underneath and between the nail and tissue. 3. Paint Pedherent (Pedinol Labs) on and allow to dry thoroughly. This process is continued until spacing appears in the nail groove. After the spacing has formed, Tanner uses a piece of celastic approximately 3/4" in length, 1/16" in width and about 1/32" in thickness. The groove is painted with Tincture of Merthiolate. The celastic is dipped in acetone and allowed to dry for about 30 seconds before packing it into the nail groove. The celastic is conformed to the shape of the groove and Pedherent is then applied. This procedure is repeated monthly for six months.

RECENT FINDINGS IN MUSCLE PHYSIOLOGY RESEARCH

J. J. Bartlett, Fla. Chir. Ass'n. Footprints, 2:3, Sept. 1957.

"One daily maximal contraction of a muscle, held momentarily, will cause that muscle to grow in strength as fast as it can."

This statement is backed through research in muscle physiology at the Max Planck Institute for Arbeitsphysiologie in Dortmund, Germany. The research done by Dr. Erich A. Muller of the Institute pointed out that a single maximal contraction, once a day, would increase the strength of a muscle an average of 4% a week.

If the above is fact and not theory, Chiropody-Podiatry would have an aid in its work of foot and leg rehabilitation. It would mean that repeated strenuous exercises could be replaced by simple non-consuming ones.

LESS COMMON SKIN DISEASES

H. I. Hecht, Footprints of Florida Chiropody Association, 3:4-6, Nov. 1957.

A review of the etiology, signs and symptoms, and treatment of the following skin diseases: Psoriasis, Lichen Planus, Pityriasis Rubra, Idiopathic atrophy of the skin, Tuberculosis verrucosa and melanoma.

COMPOUND TINCTURE OF BENZOIN AND HELOMA MOLLE

Charles A. Newman, British Chiropody J., Aug. 1956.

The technique adopted by Newman was to paint the soft corn and the whole of the opposing skin surfaces down to the web with Compound Tincture of Benzoin. This technique was used where the heloma molle was surrounded with maceration. The method of choice, where there was no macerated tissue, consisted of a daily application of Compound Tincture of Benzoin to the lesion and extending approximately an eighth of an inch beyond its margin. The tincture was allowed a few seconds to become tacky and then the corn was covered with a disc of white lint cut as closely as possible to the size of the painted area.

Newman states that this method has offered him successful results and that in

many cases complete resolution of the tissue was affected. He feels that the tackiness of the Benzoin adhered the opposing interdigital skin surfaces on either side of the soft corn thus splinting the soft tissues which in turn reduced the friction.

BLOOD URIC ACID LEVELS IN CHIROPODY

Nancy Lu Conrad, Current Chiropody, 9:9, Sept. 1957.

One of the more common blood chemistry evaluations in the practice of chiropody is the uric acid level determination used as an aid in the diagnosis of gout. Conrad states that the results of this test can be misleading, especially an atypical clinical picture, slightly suggestive of gout with an elevated level, may not necessarily be a case of gout. Examples stated are the diabetic patient who may be bordering on acidosis, patients with nephritic conditions and urinary obstruction. In patients with blood dyscrasias as well as severe anemias, there is evidence of an increased level, and it may also occur in acute infections.

Another phase of concern is a decreased uric acid level. As salicylates tend to decrease this level it is important to know whether patients have been taking salicylates immediately prior to the ordering of blood uric acid tests.

BILATERAL OSGOOD-SCHLATTER'S DISEASE

Case report, R. R. Brain, J. Canadian Ass'n of Chiropodists, Feb. 1957.

Brain presents a case report on a thirteen-year-old boy whose chief complaint of two weeks duration was soreness and swelling on the anterior and lower aspect of both knees. The parents' concern was for their son's limping gait.

Examination revealed slight edema over both tibial tubercles with the swelling extending into the left infrapatellar space. The areas were sensitive to digital pressure as well as to passive and active extension and flexion of the knees. The pain was minimized with knees in a semiflexed position.

X-ray examination revealed multiple fragmentation of the tibial apophysis with rarefied areas along the edges. Treatment consisted of immobilization by plaster casts to both legs and confinement to bed for four weeks. The child was allowed up for meals and bathroom privileges. Following his four week bed rest the child was again allowed to return to school wearing flexion-limiting knee strappings. By the 7th week complete motion in both knees was performed without pain.

Such patients should be referred to their family physician for detection of any endocrine disturbance.

CAPILLARY DISTENSION

S. Pitts, Chiropody Review, 10:20-21, October 1957.

Distension of blood vessels is common and is to be observed on any site of body or limbs.

Dilation, broadly speaking, means "an expansion of" or "an enlargement of." If dilation is applied suddenly, with extreme force or with great frequency, the tissues affected may lose some of their elasticity and remain dilated, in which case the condition of distension is present.

Hyperhidrosis is frequently accompanied by distended arterial capillaries. In such cases the distension is to be seen as a thin red line around all affected areas.

This condition is common in weight-bearing areas where the vessels are subjected to continuous flushing. Subsequently the arterial capillaries lose their elasticity and become distended. With extra blood there is additional heat and pressure. The pain is increased on resting and is experienced along the line of distension.

Pitts clearly discusses the reasoning behind the increase of pain when the body is at rest.

BOOK REVIEWS

FEATURE SHOE MANUAL

Charles A. Roberts, B.S., D.S.C., Lecturer; Author; Teacher and Researcher on Foot Balance, Shoes and Applied Shoe Therapy; Chairman, Shoe Therapy Committee, National Association of Chiropodists 1954; $1.50, 60 pp with illustrations, Charles A. Roberts & Son, Sherman, Texas, 1957.

This book presents the most complete up-to-date picture of the present status of feature shoes in the United States. The author has drawn from a storehouse of knowledge gained during his forty years' experience in the continuous contact with the feature shoe business to bring to the doctors one of the only modern cross reference books on feature shoes. It has taken more than five years to accumulate the necessary data for the book's preparation.

The book was primarily designed for the doctor who recommends or prescribes basic footgear. It is divided into five sections and contains such salient points as the definition and illustrations of shoe features: manufacturers' product classification cross reference; comprehensive listing of feature shoe brand names; and the names of many items, charts, books, films, etc., which can be procured by the doctor on request.

In the preface, the author relates some very interesting observations gained from his vast experience. Features are not incorporated in shoes specifically for any one individual or for any one foot condition. A feature is built into a shoe for one of two purposes. Either it is functional and is intended to encourage foot function and foot balance, or it is non-functional and has comfort and advertising value. If a feature is functional, it should: (1) Aid foot function and foot balance while standing or walking. (2) It should prevent distortion of the shoe under the forces of standing or walking. (3) It should conform to the contour of the foot.

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The materials were tested by soil burial, simulated tropical storage, shelf storage under laboratory conditions, agar plate exposure, and agar plate exposure after shelf storage. Cellulolytic fungi were used as test organisms. Conclusions were based on general appearance and breaking strength data, chemical analyses, and visual observations. PB 131158 an evaluation of fungicidal treatment in cotton cargo parachute webbings stored at Wright Air Development Center. E. F. Little, Wright Air Development Center, U. S. Air Force. May 1957. 98 pages. $2.50.

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library at a cost of fifty cents for five consecutive pages.

ANALGESIA ANESTHESIOLOGY

A Clinical Investigation of Monocaine, R. M. Adelman. Internat. J. Anesth. 3: 74-82, 1956.

A clinical study of monocaine showed that this agent compares favorably with a standard solution of procaine. Favorable results were obtained with a concentration of a 1 per cent monocaine with 1/75,000 epinephrine in such operations as alveolectomies, surgical removal of roots, and ordinary extractions. Three solutions were compared: (1) procaine 2 per cent, epinephrine 1/50,000, made isotonic by 0.5 per cent NaCl; (2) monocaine 1 per cent, epinephrine 1/75,000 in .1 per cent sodium bisulfite and .8 per cent NaCl; (3) monocaine 1 per cent, epinephrine 1/75,000, each cc. containing sodium sulfite .001 Gm., NaCl .008 gm. (all isotonic). All showed satisfactory results, but Solution 1 was slightly more effective than the others, whereas hemorrhage and abnormal symptoms were least in Solution 3. Solutions 1 and 3 were of longer duration than 2, but all were sufficiently long for the average dental operation. Close correlation was noted between Solution 2 and 3 to Gaffney's solution of 1 per cent monocaine and epinephrine 1/75,000, though Gaffney's solutions were not isotonic.

ARTHRITIS; RHEUMATIC DISEASES

Rheumatoid Arthritis and What Can Be Done About It, J. W. Sigler and D. C. Ensign. J. Kentucky Med. Assoc. 54: 771-79, 1956.

Control of rheumatoid arthritis requires cooperation with a long-term program. Trying various irregular treatments should be discouraged. The objectives of treatment are relief of symptoms, improvement of the general health level, prevention of crippling, arrest of the disease, and, later, improvement of functioning of the damaged joints, and adjustment of the patient to incorrectable residuals. Symptomatic therapy consists of rest, often with short periods of hospitalization, and rest of painful joints by splints or casts. Salicylate therapy should be pushed, with reduction of dosage if gastric irritation or tinnitus occurs. A balanced diet of high protein and protective foods is helpful. Obvious focal infection should be treated with antibiotics. Massage should be directed to muscles in the region of involved joints. Intra-articular hydrocortisone acetate or hydrocortisone tertiary butylacetate may relieve joint pain. Organic salts of gold (aurothioglucose) may be given intramuscularly, the initial dose 5 to 10 milligrains, with subsequent weekly doses increased by 5 milligrains until the dose of 25 milligrains is reached. Hazards of this treatment must be considered. Steroid and hormone therapy may be used concomitantly as supplements. ACTH is useful in controlling acute symptoms in hospitalized patients. The author found phenylbutazone not very effective in peripheral rheumatoid arthritis, but effective in rheumatoid spondylitis.

Diagnosis and Treatment of Gout, J. H. Talbott. Journal-Lancet 76: 190-95, 1956.

In typical acute gouty arthritis the onset of acute joint pains is sudden, with max-

imum pain within a few hours. Erythema, swelling, pain and heat in the peripheral joints should arouse suspicion of the disease. The attack may be precipitated by direct trauma, a nonarticular infection, dietary indiscretion, emotional upset, or parenteral administration of drugs. The most susceptible structure is the metatarsalphalangeal articulation of the great toe, but gout may occur in any articular surface of the feet, ankles, knees and wrists. It is a familial disease and 20 men are affected to one woman. Uric acid concentration in the serum is a diagnostic aid, but elevated uric acid does not necessarily indicate gout. Response to colchicine is diagnostic and therapeutic. X-ray evidence of punched out areas of bone adjacent to articular spaces indicates that previous attacks have occurred; however, these occur also in rheumatoid arthritis. The ancillary aids in diagnosis are albuminuria, mild hypertension, and urinary tract calculi, together or singly. Approximately one-third of the patients in this series had an elevated blood pressure.

Colchicine by mouth is the drug of choice in therapy, particularly in an acute attack, 0.5 or 0.6 mg., two doses every two hours, or one dose every hour until the joint pain is relieved. Mild attacks require 4 to 5 tablets; the average dose for a medium weight person is 10 tablets. Side effects (nausea, vomiting, diarrhea) are treated with a dose of 5 cc. tincture of camphorated opium (paregoric), repeated every two hours until gastric symptoms are relieved. In some cases of severe gouty arthritis, 2.5 mg. of oral colchicine in divided doses and 800 mg. phenylbutazone in divided doses over a period of 6 to 8 hours have brought remissions, but phenylbutazone if continued can have dire side effects. Colchicine has a low toxicity. Additional measures consist of rest of the affected joints, bed rest with use of a cradle for bedcovers if necessary, abundant fluids and a light diet. The affected joint should be used as soon as distress subsides. Patients are advised to take colchicine between attacks; no patient with moderate or severe gout should go without this drug for any length of time. Benemid may be taken in addition to colchicine by patients with moderate or severe gout, but not by those mildly afflicted unless the serum uric acid level is high. A suitable diet is low in purines (liver, kidney, sweetbreads, anchovies), but balanced in regard to carbohydrates, proteins and fats. Obesity should be avoided. Prognosis in most patients is favorable.

Phenylbutazone in Nonarthritic Rheumatism, E. W. McCormick. G P 14: 95-97, Sept. 1956.

Phenylbutazone is the best drug available for treating acute attacks of rheumatism, but long continued administration is dangerous, and repeated courses may cause ill effects due to sensitization. The effect is cumulative. Some patients are relieved in 24 hours; others not for two to three days. It must not be given to patients with peptic ulcer, even if the ulcer is inactive. Unless taken orally on a full stomach it may cause dyspepsia. Since the drug upsets electrolytic balance, use of salt must be restricted. Blood counts are necessary; although the hemopoietic system was not affected in any of this series of 200 patients reported, anemia occurred in three patients. Patients with a history of allergy should be watched for allergic symptoms. Two tablets (100 mg. each) are given after meals for three doses; then one tablet after meals for three doses; thereafter one tablet twice a day for one to two days. In most acute cases a total dosage of 12 to 15 tablets was not exceeded. Further use will not be helpful if relief is not obtained in that time. In some cases the drug was discontinued if no improvement was noted within 48 hours. No patient was treated for more

than one week. The danger of developing agranulocytosis is estimated at 1 in 100,000 patients treated. The types of cases treated in this series were fibrosis of the neck and head, brachialgia of the arms, pectoral and intercostal fibrosis, lumbar fibrosis, bursitis of the knee, plantar fibrosis (acute gout), and fibrositis of other regions (coccygodynia).

Some Observations on the Therapeutic Significance of Hydrocortisone Injections in Rheumatoid Arthritis, E. Sairanen. Acta Rheum. 2: 124-28, 1956.

The effect of hydrocortisone injections was noted in 133 unselected patients with rheumatoid arthritis, who received a total of 577 injections into the joints. Very good effects were obtained only with injections into finger joints; the benefit was much poorer in other joints. The good effect was of such short duration, the drug was not considered of much value.

Prednisone in the Treatment of Patients with Rheumatoid Arthritis, O. Gronbaek. Acta Rheum. Scand. 2: 65-74, 1956.

Prednisone has an antirheumatic potency three to five times that of cortisone; its effect is more rapid and its toxicity small. Unlike cortisone in therapeutic doses it does not cause sodium retention nor potassium loss. But the carbohydrate metabolism is changed; the gluco-corticoid effect is more intense during treatment and diabetics require higher doses of insulin and specific precautions. Twenty-nine patients with rheumatoid arthritis were given 15 mg. daily in three divided doses. None showed severe side effects; one had delayed wound healing. Eight of the 29 derived no benefit. This new drug seemed to be an effective antirheumatic agent.

Differential Diagnosis and Treatment of Rheumatoid Arthritis, C. R. Glassmire. J. Maine M. A. 47: 241-46, 1956.

Rheumatoid arthritis is a systemic disease which may be attended by widespread involvement, such as skin lesions, eye involvement, pericarditis, muscular atrophy, disease of the peripheral nerves, premature aging of the spinal cord, or by a subcutaneous nodule which is the most pathognomonic symptom. The diagnosis of rheumatoid arthritis is difficult when the usual symptoms of symmetrical, progressive joint disease with systemic manifestations are absent. The disease must be differentiated from psychogenic rheumatism, periarticular fibrositis, palindromic rheumatism, rheumatic fever, specific infectious arthritis, gouty arthritis, degenerative joint disease, and collagen disease. Treatment consists of adequate mental and physical rest, immobilization of swollen joints by use of splints where possible, physiotherapy and drug therapy, preferably the salicylates. Deformities should be prevented by use of corsets, braces, proper shoes and plaster splints. Blood transfusions may be required to correct anemia. Cortisone therapy has proved of value in patients with arthritis of one year duration or less, but undesirable side-effects occur in a large percentage of cases; most of them are reversible unless the therapy is prolonged. Relapse occurs when the drug is discontinued. Although the steroids have not proved a panacea they are a useful tool in management of this disease.

CIRCULATORY SYSTEM

Varicose Veins (Editorial). Heart Bull. 5: 72-75, 1956.

The lesser saphenous vein is affected in only 10 per cent of cases of varicose veins; the greater saphenous vein and its tributaries are most often involved, but sometimes both systems and the vessels connecting them with the deeper veins are affected. In patients having varicose veins a stasis of blood, or even a reversal in the direction of flow, may occur especially if the valves of the greater saphenous vein are incompetent and the patient is standing erect. Secondary

effects of varicose veins frequently result from increased pressure within the tissues due to congestion in the venules and capillaries. Symptoms may be minimal and treatment asked only for cosmetic reasons. In other cases symptoms may include tired leg muscles, a feeling of fullness, soreness or congestion in the region of the affected veins, muscular cramping at night, edema of the lower part of the leg and eczema and burning pain in the leg. Examination should determine whether the incompetence is of the greater saphenous vein, the lesser saphenous veins, or the femoral and politeal veins. After inspection of the appearance of the leg, the varicose vein is palpated if possible to its origin. The compression test or the percussion pulse transmission test may reveal the course of the vein if palpation brings doubtful results. The McPheeters and Kusz test differentiates between varices of the greater and lesser saphenous veins. Venous filling tests, such as the Montgomery and Zintel procedure help to determine the therapeutic method to be used. Meyers disagrees in regard to the value of this test, since he finds compression of the superficial veins by an elastic bandage is well tolerated; the deep veins are usually competent unless the patient has had iliofemoral thrombophlebitis. He finds the walking venous pressure, when properly determined, gives a more nearly accurate indication of the functioning of the deep venous system. Frequently surgical treatment is directed to the larger saphenous veins, when the lesser saphenous vein is the incompetent one. Operating upon both, "just to be sure" is not good practice.

Arlidin: A Clinical Evaluation of a Peripheral Vasodilator with Selective Action on Muscle Vessels, I. D. Stein. Ann. Int. Med. 45: 185-90, 1956.

A series of patients, 191 with arteriosclerosis obliterans, 21 with recent thrombotic closure, and 8 with thromboangiitis obliterans, all of whom had been observed for a period of 2 months to 6 years, were given tests for the presence of pulses, oscillometric and skin temperature readings, response to reactive hyperemia and exercise tolerance. These patients received one tablet of Arlidin (6 mg.) three times daily for one week; if no change occurred, the dosage was increased to two tablets three times daily. Improvement occurred in two to three weeks or the drug was discontinued. Of the 199 patients with gradual progression of symptoms, other vasodilator drugs had helped but little after an initial salutary effect. However, after taking Arlidin orally, two-thirds of this group showed a significant improvement in their ability to walk. Intra-arterial injection of Arlidin produced a considerable increase in blood flow in the calf muscles, as measured by the plethysmograph—an average increase of 200 to 400 per cent. Arlidin, therefore, seems an effective dilator of blood vessels in skeletal muscles, and is recommended in the management of intermittent claudication.

DERMATOLOGY, ALLERGY AND FUNGUS DISEASES

The Anatomy and Histochemistry of the Arteriovenous Anastomoses in Human Digital Skin, Mescon, H., Hurley, H. J., Jr., et al. Army Med. Res. Lab., Fort Knox, Ky. Rep. No. 234, 1-19, 1956.

Study of the micro-anatomy and histochemical properties of the arteriovenous anastomoses in human digital skin was made by use of 6 mm. punch biopsies secured from the volar pads of the great toes of 15 normal subjects aged 21-26 years, in addition to 52 specimens obtained at autopsy of patients aged 48 to 58 years. The arteriovenous anastomoses (AVA) of the skin (specialized vascular structures which shunt the blood from arterioles to venules parallel to the capillaries) form

together with the related vessels and nerves a "glomus." Although the AVA occur in the palms and soles, ears, nose, eyelids, lips, cheeks and foreheads, they occur most frequently in the pads and nailbeds of the toes and fingers. AVA are distinguished microscopically from other vessels by the thick wall surrounding a lumen only barely perceptible. In the study here reported, a staining reaction in metachromasia with toluidine blue, further differentiates AVA smooth muscle media from arteriolar smooth muscle. The "epithelioid cells" of the AVA have no chemical affinity with true epithelium for, whereas protein-bound sulfhydral glycogen and acid phosphatase are revealed in epithelial cells by staining, glycogen and acid phosphatase are absent in AVA. Because elastic membranes are lacking, the AVA can close completely, but over-extension of dilated AVA is probably prevented by the turgor of large vascular smooth muscle cells.

Some Clinical Aspects of the Diagnosis and Treatment of Vascular Allergy, Jan Waldenström. Internat. Arch. Allergy 8: 63-71, 1956.

The role of allergy in cases of widespread vascular lesions in a patient's body (polyangiitis) seems important in a certain number of cases, for asthma and unusually high eosinophile counts are important features in these cases. However, in other cases of polyangiitis (widespread arteritis "temporalis," pulmonary obliterating arteritis with pulmonary hypertension, etc.) allergy has not been proved a factor. Spontaneous remissions in periarteritis nodosa frequently occur, so that the effect of cortisone therapy is somewhat difficult to determine. During the last five years 8 to 10 cases of this disease were treated at the Malmö Clinic, some of them with cortisone or ACTH. In one case with a long illness a short course of ACTH brought a remission that lasted for almost five years. In a very serious case with many complications and in which a severe relapse occurred after a second course of sulfa drugs, ACTH was given despite the presence of severe decubital ulcers, for it seemed the best chance of saving life. His condition improved rapidly and he was dismissed in excellent condition. He was treated at another hospital six months later with sulfa drugs for angina and developed joint pains, a high fever and papules and died. Cortisone was given a few days before without effect. Another critical patient was given cortisone as a last resort and the effect was dramatic. It was felt that in severe cases of polyangiitis contraindications should not deter from giving cortisone. Occurrence of abnormal serologic reactions in some of these cases may be considered sometimes as entirely unspecific.

Spontaneous and Induced Allergies of the Immediate Type in Man, R. A. Cooke, A. Menzel, et al. J. Allergy 27: 324-31, 1956.

Considerable differences exist between spontaneous sensitivity under natural conditions, as in hay-fever, and those induced by parenteral injection of foreign serums. A case of induced allergy is reported in a man who received tetanus antitoxin for a minor hand injury and two days later developed extensive urticaria and angioedema. Four days afterward the symptoms had disappeared. Passive cutaneous anaphylaxis which is present in induced allergy is absent in the spontaneous type. Skin sensitizing antibodies are found in spontaneous allergy and also in the induced type, but muscle-sensitizing antibodies and precipitin are found only in the induced. These and various other differences noted suggest that the basic differences, now not clearly understood, lie in the site of antibody production, or in the character and constitution of the antibodies. This question cannot be solved until it is finally understood what is the constitutional defect produced in the allergic person.

Some Vascular Effects in Allergy, G. W. Pickering. Internat. Arch. Allergy 8: 60-62, 1956.

A study was made of the effect of cortisone upon vascular response of the skin to various agents. Patients were used in the experiments who were receiving cortisone or ACTH in treatment of rheumatoid arthritis and other diseases not primarily affecting the skin. Cortisone had no effect on skin responses to histamine, morphine and pollen; the tuberculin reaction was reduced from 15 to 170 times in size by cortisone and ACTH; they also reduced the response to manganese butyrate to a much less extent. The time relations of the response to pollen was suggestive of a reaction between antigen and antibody occurring on or near the surface of the cell. The delayed response caused by cortisone is not understood, but the author suggests that the release of intracellular enzymes, especially proteases, is concerned; the role played by cortisone remains speculative.

The Mycoses as a Therapeutic Problem: Survey of 348 Cases, F. Miedzinski and J. Lipski. Brit. J. Derm. 68: 200-03, 1956.

In Poland every case of ringworm must be reported to the public health centers and all persons suspected of having fungus disease are given a thorough examination and free treatment. Of 348 cases of mycoses treated (1946-54), 248 were cases of tinea trichophytica of the scalp, 72 of tinea favosa, 45 of kerion celsi, and 9 of onychomycosis trichophytica or favosa. Diagnosis was established by clinical and microscopic examination and use of Wood's light. Patients are treated for tinea capitis in the hospital by epilation and by use of irradiation. They are followed up for 4 to 6 months or until microscopic examination shows no fungi. Relapses occur in about 7 per cent in cases of tinea trichophytica and 9 per cent in cases of tinea favosa, due to faulty epilation or to inadequate application of topical drugs by the out-patient. Onychyomycosis tends to recur after surgical removal of the affected nails. Prophylaxic measures consist of thorough examination of children in school and nurseries and of children in large families where a case has occurred.

DIABETES; GANGRENE

Management of Foot Lesions in the Elderly Diabetic, D. Hurwitz. J. Amer. Geriatrics Soc. 4: 648-53, 1956.

About two-thirds of all hospitalized diabetics at the Boston City Hospital are admitted for treatment of foot lesions. A complete physical examination is done to detect other complications and an adequate diet high in proteins is prescribed. The diabetes is brought under control; often the patient receives more than his usual dosage of insulin because of the infection. The urine is kept as sugar-free as possible without causing hypoglycemia. Cultures are made of the affected tissues and antibiotics administered. Penicillin in doses of 600,000 to 1,000,000 units are given daily if no open lesion exists. The affected area is given wide drainage within 24 hours and repeated as necessary. Delay of one week may make amputation necessary. High amputation is not considered until after two weeks of conservative treatment, after which it is rarely necessary. Gangrene has a poorer diagnosis. A toe or a transmetatarsal amputation may be necessary, or a below-knee amputation, if there is a good popliteal pulse. Elderly patients given a high amputation if they have a mental and physical equipment to adjust to a prothesis, should have the stump shaped properly with bandages immediately after operation, and the stump exercised to prevent flexion deformities. Sympathectomy is of little value in elderly patients with peripheral vascular disease.

DRUG THERAPY

Streptokinase Intramuscularly in the Treatment of Infection and Edema, J. M.

Miller, J. A. Surmonte, et al. Postgrad. Med. 20: 260-67, 1956.

Streptokinase was administered intramuscularly in various cases of edema and infection. In case of acute cellulitis, lymphangiitis and lymphadenitis of the lower extremities, 5,000 units were given twice a day for three days. Most patients were benefited after 24 hours. No aggravation of the infection or delay in wound healing occurred. In 10 per cent of the patients a rise in temperature occurred but was controlled by drug therapy. Sixty per cent had some pain and tenderness at the site of injection. An antibacterial drug should be given with the intramuscular injection of streptokinase. Streptokinase should not be given to a patient known to have a defective clotting mechanism.

Skeletal Muscle Relaxants, J. D. P. Graham. Practitioner 177: 333-40, 1956.

The muscle relaxants are classified as centrally acting and peripherally acting. Those centrally acting include diethazine, ethopropazine, benzhexol and caramiphren, all of which are of some value in control of rigidity and tremor in Parkinsonism. Mephenesin (myanesin, tolserol) is an anticonvulsive and potent local anethetic but may have serious after-effects. The neuromuscular blocking agents, which are curariform in type (*d*-tubocuraine and gallamine) produce a reversible paralysis by raising the threshold of the end-plate region of muscle fibers. The margin between the amount required to produce adequate relaxation of skeletal musculature and the amount likely to reduce diaphragmatic movement is dangerously small. The persistent depolarizing agents, suzamthonium and suxethonium, cause preliminary fascicular contractions, followed by brief paralysis. The brief action of these drugs makes them useful in facilitating intubation and in endoscopy of bronchus and esophagus, and also in stopping persistent hiccough in patients undergoing ophthalmic surgery.

MEDICAL PRACTICE; REHABILITATION

Current Trends in Physical Medicine and Rehabilitation, A. L. Watkins. Arch. Phys. Med. 37: 221-24, 1956.

The orthopedic surgeon continues to care for the patient with disease of the bones or joints, even though orthopedic surgery is not required, but, rather, rehabilitation in the form of physical and occupational therapy, for example, in infantile paralysis or cerebral palsy, and after-care following fracture and reconstructive surgery. Neurologic treatment of chronic diseases and internal treatment of rheumatoid arthritis and cardiac disease requires cooperation with the physical therapist and use of physical medicine. Those treating pulmonary disease, such as tuberulosis, are concerned with rehabilitation of the patient. The physiotherapist is specially trained like all specialists, particularly in applied biophysics as used in rehabilitating patients. Since medical rehabilitation is closely allied to the practice of medicine, it should be directed and supervised by a physician. Ultrasound, a mechanical vibrating energy of frequency greater than sound, has proved in preliminary studies to be a valuable physical therapeutic procedure, but since it causes damage when improperly used, it should be used only by a physician familiar with its biophysical effects. At present, many residencies in the field of physical medicine remain unfilled.

Financial Arrangements for the Practice of Physical Medicine and Rehabilitation, O. O. Selke, Jr. Arch. Phys. Med. 37: 477-79, 1956.

By means of questionnaires sent to diplomates of the American Board of Physical Medicine and Rehabilitation, a survey was made to determine how physical medicine and rehabilitation is being practiced according to business arrangements. About

65 per cent of the income of physiatrists is derived from salaries; 82 per cent of them derive all or part of their income from salary arrangements; 84 per cent spend their entire practice in physical medicine and rehabilitation; 54 per cent receive part of their income from private fees; 12.5 per cent derive all their income from private practice; 38 per cent have private offices apart from hospital affiliations.

Mobile Home Treatment for Rheumatism and Arthritis, T. F. Hines, G. K. DeForest and E. L. Nyman. Brit. J. Phys. Med. 19: 145-47, 1956.

The Mobile Physical Therapy Home Treatment Unit of the Yale-New Haven Medical Center aims to bridge the gap between hospitalization and outpatient care. Only clinical patients are eligible for this treatment. The charges range from no charge to a maximum of $2.50 per treatment. The actual cost of treatment averages $5.00 and is financed by the Connecticut Chapter of the Arthritis and Rheumatism Foundation, the State, and other agencies. About 12 patients are treated per month. A total of 12 patients were treated the first year, with a total of 818 patient visits.

MUSCULOSKELETAL SYSTEM

Electromyographic Study of the Muscles of the Foot in Normal Walking, F. J. Sheffield, J. W. Gersten and A. F. Mastellone. Am. J. Phys. Med. 35: 223-36, 1956.

The electric activity of 12 muscles of the foot were studied in 10 normal subjects, by means of surface electrodes. Electric activity in a muscle occurs (1) when it is shortening and actively accelerating a part; (2) when it is lengthening and decelerating motion of an extremity; (3) when it is maintaining a constant length and stabilizing a joint. The dorsiflexors (tibialis anterior, extensor digitorum longus, and extensor hallucis longus) act almost in unison. With rather steady activity during swing, they shorten to dorsiflex the foot, thereby providing adequate clearance during swing. The peak of activity, beginning just before toe-off, lasts while these muscles are producing dorsiflexion in order to clear the ground; electric activity decreases toward the end of the swing. A second peak comes at heel strike, especially in the tibialis anterior muscle. The maximal electric activity of the digitorum longus and tibialis posterior begins at metatarsal strike, continues until the metatarsal is off the ground or immediately afterward, then slowly diminishes until the toe leaves the floor. There is no electric activity from that time until the next metatarsal strike. The gastrochemius in 80 per cent of subjects also begins its activity at the time of the metatarsal strike, continuing until the metatarsal leaves the ground, then decreasing until the toe leaves the floor. The soleus in contrast to the gastrochemius and other plantar flexors of the foot, shows constant, although slight, activity during the swing phase of walking and in the early stance phase. Activity of the abductor hallucis and flexor digitorium brevis begins at the metatarsal strike at the time of flexion of the phalanges. The extensor digitorum brevis in most subjects shows low grade activity during the swing and the stance phases, with slight increase at the toe-off and immediately following heel strike. These electromyography studies therefore allow examination of several muscles simultaneously and determination of which muscles are active during specific movements and approximately how much movement is present.

Trimalleolar Fracture, H. C. Amrein. J. Maine Med. A. 47: 170, 1956.

A man was caught by the sleeve in an overhead shaft; his right arm wrapped around the shaft; when he was thrown into the "kicker-machine" he received a severe blow on the left ankle. Besides a fracture of the right ulna, the left ankle had a frac-

ture of the internal malleolus with displacement and twisting, and acute angulation of the external malleolus at the lower end of the fibula. Open reduction was done after closed reduction failed because the hallicus longus tendon had slipped between the fractured malleolus and the tibia. After placing the hallicus longus tendon in normal position, the malleolus, still attached to the deltoid ligament, was screwed firmly in place with a screw 2½ inches long. On opening the lateral aspect of the ankle joint, the tibial-fibular ligament was found intact, but to insure a tight joint mortise a screw was put through the exterior malleolus to tighten the fibula against the tibia. The screw extended through the anterior cortex of the tibia and was palpable through the skin. This method of using two screws is better than the old technique of using a bolt, since erosion from pressure is avoided. The patient walked without pain or swelling five months later; his only loss of motion was five degrees of dorsi-flexion. He refused to have the screw extending through the interior cortex removed as it did not annoy him.

NEUROLOGY

Non-Anemic Neuropathy Due to Deficiency of Anti-Pernicious-Anemia Principle, P. Bastrup-Madsen. Acta Psychiat. & Neurol. Scand. 31, Supp. 108: 35-46, 1956.

Six patients with subacute degeneration of the spinal cord associated with histamine-fast achlorhydria, were found to have a hemoglobin concentration and RBC counts within normal limits. Though the bone marrow showed no erythropoiesis, typical megakaroblastic dysplasia of granulopoiesis indicated a deficiency of the anti-pernicious anemic factor. When the bone-marrow was re-examined after specific treatment, the maturation disturbances had disappeared. The neurologic manifestations were present from 6 months to 2 years in three subjects; in the remaining three patients from 8 to 20 years before examination of the bone-marrow was performed. In all patients the disease had progressed to a crippling condition before specific therapy was indicated. In two patients this therapy was followed by slight improvement in the neurologic condition. These cases seem to indicate that the neuropathy of pernicious anemia may occur unaccompanied by anemia. Since in non-anemic cases it is difficult to establish the cause of the neuropathy with certainty, it is important to know that bone-marrow examination may show deficiency of the anti-pernicious-anemia factor, even when anemia is absent. In such cases a mild deficiency is revealed by the presence of megaloblastic dysplasia of granulopoiesis. Therefore, it is assumed that non-anemic neuropathy constitutes part of Addisonian pernicious anemia and that lack of the intrinsic factor causes reduced absorption of a factor important in metabolism of nerve tissue. This factor, apparently vitamin B_{12}, plays a part in the normal function of bone-marrow nerve tissue.

NEW GROWTHS

Diseases of Bone, Louis Lichtenstein. New England J. Med. 255: 427-33, 1956.

An extensive review of the literature is prepared in regard to differential diagnosis and treatment of primary tumors of bone. Included are benign chondroblastoma, chondromyxoid fibroma, benign osteoblastoma, osteogenic sarcoma, periosteal osteogenic sarcoma, nonosteogenic fibroma, giant-cell tumor, Ewing's sarcoma, reticulumcell sarcoma, so-called adamantinoma of limb bones, and chordoma. Other tumors described are tumors of periosteal origin; tumors of synovial joints, bursas and tendon sheaths; histiocytosis X (eosinophilic granuloma of bone, "Letterer-Siew disease," and "Schuller-Christian disease"). Aneurysmal bone cyst, hereditary ochronosis and

pathologic changes in gout are briefly discussed.

Diagnostic Criteria of Malignant Melanoma of the Skin, R. P. Towers. Irish J. Med. Sci. No. 367: 310-16, 1956.

Nevi occurring in certain sites are regarded with more suspicion than those appearing elsewhere—particularly those on the soles of the feet, toes and fingers, palms, scrotum, vulva, subungual regions and any other parts of the body subject to irritation. Intradermal nevi not undergoing malignant change rarely occur on the soles, palms and genitalia; therefore, a pigmented mole on any of these sites should be considered a junctional nevus if not a malignant melanoma, and should be excised. Pigmented moles of the foot should be regarded with grave suspicion. Diagnostic criteria of early malignant changes in a melanoma has varied from time to time. Today the theory is generally accepted that junctional activity is a precursor of malignancy in most cases and that the common intradermal nevus does not undergo cancerous changes. It is further accepted that junctional activity and, therefore, malignant melanoma are under endocrine control of the anterior pituitary.

PSYCHOTHERAPY

A New Method of Treating Emotionally Induced Illness Adaptable to General Practice, J. A. Schlindler. Postgrad. Med. 20: 197-202, 1956.

After assuring the patient that the entire staff has his interests at heart, he is given a careful examination that will entirely satisfy him. Usually the patient's fears will be revealed while his history is being carefully taken. This is followed by asking the patient to fill out the Cornell Medical Indices. If no pathologic condition is found present, he is told that his body is in excellent physical condition but it is not functioning right. The patient returns next day accompanied by his wife (or husband if the patient is a woman) and they are shown the audio-visual presentation. Functional disease is explained and demonstrated by 40 examples of common syndromes seen in emotionally induced illnesses. Over 95 per cent of the patients can be convinced that they have functional disease only. During the next 12 to 15 hours the patient is shown how to overcome emotional stress. Patients who are not improved are referred to a psychiatrist. They have personality difficulties (compulsions or obsessions) which respond to no other type of treatment.

Anxiety Hysteria Presenting as "Tenosynovitis," A. L. Bass. Ann. Phys. Med. 3: 64-65, 1956.

A young soldier struck on the left foot by a baseball had recurrent attacks of "tendonsynovitis" for four years. Four years before this accident he had pain and stiffness of the left hand following a blow on the back of that hand, so that he was unable to extend his thumb, index and middle fingers. The hand was immobilized in a plaster cast for two months. A few months later symptoms recurred when the hand was hurt in a bicycle accident. He had three other attacks, without trauma, within the year. Each time elastic strapping for a few weeks brought relief. But the patient continued to have painful attacks in the foot and hand and he was confined to bed at various times, without obtaining relief. A diagnosis of a typical rheumatoid arthritis was finally made and he was treated with salicylates and later with ACTH. The patient in the next bed complained that this patient awakened him at night with his tapping on the bed. The patient denied that he was intentionally traumatizing his limbs against the sides of the bed. The psychiatrist made a diagnosis of anxiety hysteria which had been initiated at the time of the death of the patient's mother, when his first attack occurred. The casts were removed and after a period of psychotherapy the man was able to return to duty.

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

ILLINOIS

Dr. Herbert E. Longenecker has been chosen to receive the annual distinguished service award of the Illinois Interprofessional Council.

Dr. Peter N. Varzos of the Illinois Chiropody Society was Chairman of the committee which selected Dr. Longenecker to receive the award at the organization's annual banquet, January 21.

MICHIGAN

The Michigan Chiropody Association is in the process of establishing a full-time Executive Secretary and has therefore terminated the part-time services of Mr. J. R. Dawson.

MISSISSIPPI

The Mississippi Association of Chiropodists held its annual meeting on December 7 and 8, in Jackson, Miss. The following officers were elected: President, Dr. C. R. Johnson, Greenville; First Vice President, Dr. Charles M. Azarach, Columbus; Second Vice President, Dr. W. G. Trautman, Gulfport; Secretary and Treasurer, Dr. M. K. Upshaw, Jr., Jackson.

The A.P.A. delegate and alternate, elected for two years in 1956, have one more year to serve.

The Mississippi Society is undertaking legislative changes in the podiatry law during the year 1958, which consists of the use of narcotics, pre-podiatry and podiatry requirements, the recognition of the National Board of Chiropody Examiners, and the increase in fees for written examination and reciprocity licenses.

MID-WEST CHIROPODY CONFERENCE

MORRISON HOTEL, CHICAGO, ILLINOIS

MARCH 21-22-23, 1958

Dr. Gordon Bronston
"The Use of Sylnasol in the Treatment of Chronic Ligamentous Strain"

Dr. Earl G. Kaplan
"A Program for Diagnosis and Treatment of Children's Orthopedic Problems"

Dr. Bernard Egerter
"The Patient as a Unit of Practice"

Dr. Howard Reinherz
"Orthopedic Braces in Appliances for the Lower Extremity"

Dr. Morton Whittenberg
"The Negative Aspects of Injection Therapy"

Dr. Mervin Shalowitz
"Anti-Biotics and Bone Pathology"

Dr. Harry Lindy
"Medical Relaxation in Hypnosis"

TABLE CLINICS

Dr. Charles B. Brooks
"Acrylic Nail Therapy"

Dr. William Cope
"Proper Technique in Uses of Pressure Bandages"

Dr. Jerome Kraus
"A Simplified Casting Technique"

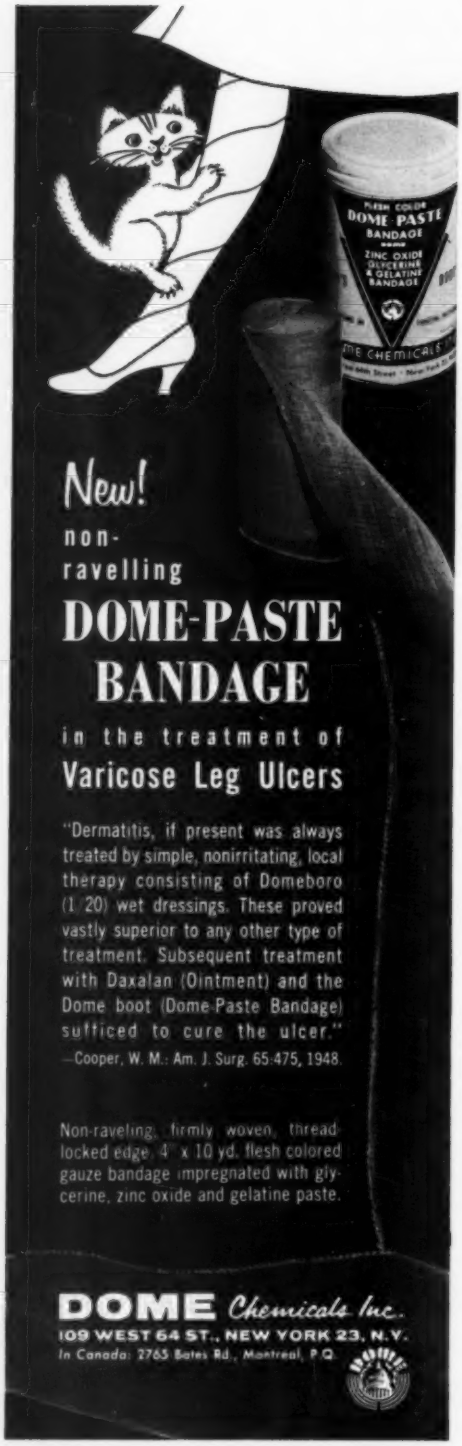
Dr. Harry Bronston
"Shoe Padding and Wedging"

Dr. Vernon Hall
"Proper Uses of Ultra-Sound"

Dr. George Guenzler
"New Splint Techniques in Everyday Practice"

Dr. Ralph Fowler
"Local Anesthesia"

Dr. N. H. Ketai
"A Review of Suturing Techniques"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—Cooper, W. M.: Am. J. Surg. 65:475, 1948.
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PENNSYLVANIA

Philadelphia

The monthly scientific meeting of the Philadelphia Chiropody Society was held on Tuesday, December 17, at the County Medical Society Building. The guest speakers were: Dr. Alexander Dallek of New York, who spoke on "Practical Office Procedures," and Dr. Alan Pasternack of Philadelphia, who discussed "Medicspray Bandage."

Dr. L. W. Marmon presented clinical evaluating pharmaceuticals produced by Smith, Kline and French Laboratories.

Western Division

The Western Division met in the Hotel Webster Hall, Thursday, January 9, 1958. Dr. David Brodie spoke on "New Concepts in Padding."

The Ladies' Auxiliary met the same evening in Carnegie Library.

AMERICAN PODIATRY COUNCIL

The topic of the January 24th meeting of the American Podiatry Council was "Moulded Shoes—Their Uses and Abuses." Speakers for the evening were: Irwin M. Murray, M.D., Milton D. Roven, Pod.D., Herbert Rausher, A.B., Pod.D., and Milton Ashur, D.S.C.

The pros and cons of individually constructed footgear were discussed together with the indications and contraindications. Legislation prohibiting casting except by a podiatrist or physician was also discussed.

P.G. COURSE

The Seton Hall College of Medicine & Dentistry, Postgraduate Department, has announced a course in Vascular Diseases for members of the New Jersey Chiropodists Society, beginning February 28-March 28, 1958.

Its purpose is to outline the diseases of lower extremities, primarily for delineation of those purely local conditions which a chiropodist is qualified and able to treat from peripheral manifestations of systemic diseases.

The anatomy lectures will consist of

blackboard diagrams and explanations followed by actual cadaver demonstrations and dissections. The physiology of peripheral circulation will be discussed with emphasis placed on the lower extremities and use of diagnostic tests, such as oscillometry and temperature reading; various manifestations of systemic diseases in the lower extremities and feet will be demonstrated.

Finally, a rational approach to therapy with indications for use of vasodilators and other therapy is presented.

Seton Hall College of Medicine and Dentistry, Department of Postgraduate Medical Education, will issue certificates to those who have satisfactorily completed courses.

AMERICAN FOOT HEALTH FOUNDATION

We in the American Foot Health Foundation know full well that you have read the appeals which have appeared in these pages during the past few months concerning the membership drive of AFHF.

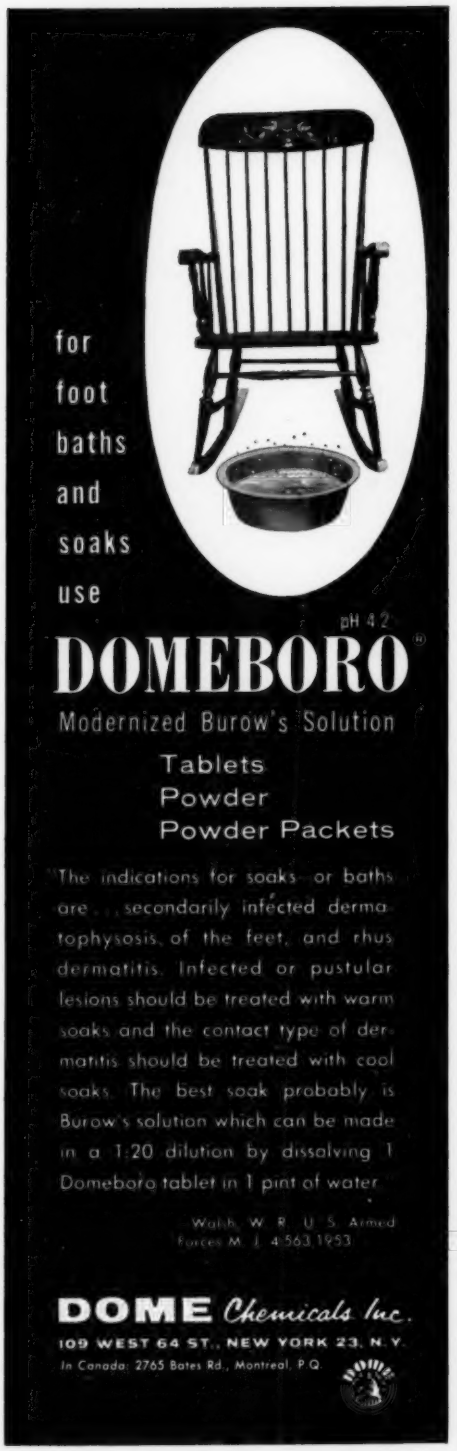
We also realize that the reason a number of you have failed to send in your membership dues so far is simply a matter of procrastination.

Doctor, you, the benefactor, are surely the last one who would want the Foundation to procrastinate in its work, so why not drop your "Do It Tomorrow" attitude and send in your $10.00 dues for 1958 today. You can be sure that we will not procrastinate in sending your Membership Certificate, the 24-page Annual Report for 1957 and Program Review for 1958.

Mail check and professional card to American Foot Health Foundation, 3301 16th Street, N. W., Washington 10, D. C.

The Board of Trustees
American Foot Health Foundation

"Chiropody As A Career" is on Indiana University's most desirable list of films. This list includes only 90 films of the thousands they have in their film library.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baths
and
soaks
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pH 4.2
DOMEBORO®
Modernized Burow's Solution
Tablets
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Powder Packets
The indications for soaks or baths are . . . secondarily infected dermatophysosis of the feet, and rhus dermatitis. Infected or pustular lesions should be treated with warm soaks and the contact type of dermatitis should be treated with cool soaks. The best soak probably is Burow's solution which can be made in a 1:20 dilution by dissolving 1 Domeboro tablet in 1 pint of water.
Walsh, W. R. U. S. Armed Forces M. J. 4:563,1953
DOME Chemicals Inc.
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COMMUNICATIONS FROM THE PROFESSION

To the Editor:

Forty-two years ago, with three knives, two nail chisels, two clippers, a cabinet, chair and stool, oh yes, let's not overlook white precipitate ointment, adhesive plaster, felt and an antiseptic of choice, I was in business! Ten dollars a day was wonderful, expenses were low. I was sitting on top of the world and out to make my first million.

I did some surgery, by the trial and error method. Strange as it may seem, the surgery wasn't too bad. My operating room experience came through the kindness of a couple of surgeons who were friends of mine. They allowed me to assist at some operations and gave advice. Through the years I progressed, this seminar, that lecture and various conventions, by gleaning a little knowledge and know-how from each of the better brains on the agenda. The years passed, surgery had improved enough to satisfy myself and some of my fellow practitioners. Results were good to excellent. Now looking ahead, with a beautiful office and all modern equipment, I decide to learn more.

Nine younger fellows from New York and this old one decide to go to the Civic Hospital in Detroit for a course in surgery. We went and if I could find words to express my grateful thanks to the staff of this institution, they would still be inadequate. This institution, where all types of foot surgery is being done, is wonderful and just think, my fellow practitioners, it is maintained by surgeons, all foot specialists, who are more than eager to teach their colleagues to do the surgery of their choice. If you do surgery or are interested in surgery (and it is an adjunct to your well-rounded practice), this course at the Civic Hospital is the best investment you can make. My surgical technique has improved 50% and I have stopped wondering if it is perfect.

KERAMIN INJECTION
A Physiologic Approach!

Keramin Injection (Steinberg's Solution) provides an abundance of vitamin A to a tissue which is normally vitamin A starved. This causes physiologic changes in the epidermis which appear to render the "soil" unfavorable to the existence of such hyperkeratoses as verrucae and helomata.

Literature and information is available from

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1958 REGION 3, CHIROPODY CONVENTION

9th Annual Post-graduate Science Conference

Delaware, Maryland, New Jersey and Pennsylvania

Thursday, Friday, Saturday and Sunday

APRIL 17, 18, 19 and 20, at The Ambassador, Atlantic City, N. J.

Scientific Program

FRANKLIN CHARLESWORTH, F.Ch.S., Manchester, England —
"COMPARATIVE INTERNATIONAL CHIROPODY"

A presentation of European chiropodical theories, techniques, methods and appliances including illustrated descriptions and practical demonstrations of casting processes, some of the lecturer's original orthopedic and prosthetic devices. Specialized preventive and corrective treatment methods for podopediatric and geriatric conditions.

Comparative discussion of European and American chiropodical concepts, techniques and appliances by an authoritative panel including: A. Rubin, D.S.C., Washington, D. C.; Leonard Hymes, D.S.C., Pleasantville, N. J.; John T. Sharp, D.S.C., Abington, Pa.; Sidney Sivitz, D.S.C., Lewistown, Pa.; Jerome S. Gross, D.S.C., Philadelphia, Pa.

JOSEPH W. GILDEN, D.S.C., F.A.S.C.R., Fairfield, Conn. —
"BASIC FACTORS FOR PROPER POSITIONING FOR RADIOGRAPHS"

An illustrated presentation of procedures necessary to produce the best diagnostic views through proper X-Ray positioning.

NATIONAL OFFICERS TEAM PRESENTATION–JONAS C. MORRIS, D.S.C., Audubon, N. J.

A. "Medical Service Plans." B. "Development of Educational Facilities." C. "Broadening Our Medical and Hospital Relations."

A. RUBIN, D.S.C., Washington, D. C. — "How Can I Take Advantage of Services Offered by Our National Organization?"

An exposition of plans, objectives and general progress of our National organization.

SEYMOUR H. BLAU, D.S.C., Jersey City, N. J. —
"SKIN PLANING IN CHIROPODICAL SURGERY"

The premiere showing of a color motion picture film depicting the complete techniques of skin planing in chiropody for verruccae, scars and keloids.

G. ELMER HARFORD, D.S.C., Philadelphia, Pa. — "NEEDLE POSITIONING"

A graphic demonstration and teaching session illustrated by X-Rays, color slides and motion picture films explaining proper needle positioning for injection of local anesthetics and other injectables. Diagrammatic "take-home" charts will be distributed to all registrants attending this lecture.

RAYMOND K. LOCKE, D.S.C., Englewood, N. J. —
"HOW TO ESTABLISH A HOSPITAL CHIROPODY SERVICE"

Detailed presentation of step-by-step procedures in establishing and maintaining a Hospital Chiropody Service. Color and sound film of the Hackensack, N. J., Hospital Chiropody Service in operation, including procedures and techniques useful in daily office practice. Commentary by Dr. Locke. Discussor—Isadore P. Forman, D.S.C., Philadelphia, Pa., Chairman of our National Hospital Chiropody Service Committee.

PROBLEM CLINICS: —

AMERICAN COLLEGE OF FOOT SURGEONS conducting a Surgical Problem Clinic.

AMERICAN COLLEGE OF FOOT ORTHOPEDISTS conducting an Orthopedic Problem Clinic.

All registrants are invited to present their problem case histories, X-Rays and questions for consultation and expert opinions.

ROBERT SAPPENFIELD, Philadelphia, Pa. — A professional instructor in leadership and human relations courses presents:

"ARE CHIROPODISTS PEOPLE TOO?"

"HOW TO BETTER PRESENT OURSELVES TO OUR PATIENTS"

An authoritative analysis based on a comprehensive personal survey of our profession.

ABRAM A. SIMON, D.S.C., Caldwell, N. J. —
"CRITERIA FOR HYPODERMIC NEEDLE SELECTION"
"TECHNIQUE FOR PAINLESS PLANTAR INJECTION"
"CARE OF SYRINGES, NEEDLES AND INJECTABLES"

A post-graduate review of basic information requisite to the most effective use of hypodermic equipment.

STANLEY A. BELOFF, D.S.C., Philadelphia, Pa. —
"HEMATOLOGY — ITS PRACTICAL APPLICATION IN CHIROPODY"

Indications for and diagnostic significance of the Blood Report.

ANTHONY A. GRIECO, D.S.C., Hoboken, N. J. —
"USES AND APPLICATION OF A RESILIENT SELF-MOULDING AND SETTING COMPOUND"

Detailed demonstration of an increasingly popular office moulding modality.

RUBEN ROSEN, D.S.C., Philadelphia, Pa. — "SANDAL FABRICATION"

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Registration $10.00. Mail check or money order to

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The surgeon instructors are sincere, their time is gratis (no fees are accepted by the staff for teaching), they are courteous, kind and patient to the finish. The course is excellent, equipment at hand for surgery is more than adequate and you learn by experience under excellent supervision.

Every practitioner should know the Civic Hospital and its surgery course as a must for all young practitioners and we older fellows derive much benefit with a refresher course. I am glad that at last some of the younger men of our profession have accomplished what I predicted forty-two years ago in a paper on the future of podiatry, a hospital for foot problems, manned and administered to by foot doctors who are a credit to the profession of podiatry and the medical arts and sciences of which we are a neglected part.

FRANCIS S. SCHWARZ,
M.Cp., Pod.D., F.A.A.C.
Troy, N Y.

To the Editor:

I wish to make a comment regarding Mrs. C. Gamble's article on "A Wife's View of Chiropody-Podiatry."

May I first take my hat off to Mrs. Gamble and next turn to Dr. D. Gamble and tell him that if he does not or has not taken his wife's advice on matters concerning his office, he had better begin now if he wishes to implement a good future office, speaking from the mechanical and/or physical structure.

My wife has taken an interest in my office over the past eleven years and wherever there arises an alteration in the physical outline of the office itself, I go to her for advice. Her perspective is slightly varied from ours for we are so very close to it and probably adhere too strictly to professional protocol, even to the point of becoming ridiculous.

Instead of spending my time telling other doctors just how much information I possess, I continue to study and read and use

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originator of foot balance inlays is directed
in all its endeavors to accomplish this result

that knowledge to facilitate advanced professional care to the patients who seek procedures or professional advice. Fortunately, most of the doctors are doing just that, and as a result, chiropody-podiatry procedures are fast becoming known.

Mrs. Gamble is so correct when she states that the best advertising is done over the card table or social gathering, by one who is interested in your present and future. My belief has always been that the doctor's wife is his finest public relations personnel director.

L. F. Lucas, D.S.C., F.P.R.S.
Minneapolis, Minn.

To the Editor:

The change in terminology of our N.A.C. to A.P.A. is opposed by the Oklahoma Chiropody Association, Inc.

A poll conducted in Oklahoma on December 1957 reveals almost unanimous desire of the membership for the designation Chiropody-Chiropodists at both state and National level.

An official special emergency meeting of the Oklahoma Chiropody Association, Inc. was held Saturday, January 4th, 1958 at the Mayo Hotel, Tulsa, Oklahoma for the purpose of discussing the title change of our parent body by the 1957 House of Delegates and the N.A.C. Executive Councils' announcement of publicity releases on January 14th.

If Oklahoma's attitude toward the action of the 1957 N.A.C. House of Delegates is an indication of doctors of Surgical Chiropody in other States, the attempted change in name will boomerang to the detriment of those who prefer Podiatry instead of to our profession's best interests.

Oklahoma Chiropodists feel the Podiatry wing's whole scheme is deceptive, misleading and designed to benefit the Podiatrists of our profession regardless of the bad effects on those who prefer Chiropody.

The facts are that the Executive Council Sub-Committee not once asked the doctors who pay dues for membership their opinion, wishes or desires. Power of author-

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ity, in our opinion, was usurped.

We believe that the Podiatry wing's announced scheme and plans are the product of the Alumni of the First Institute of Podiatry and those others they could persuade.

After careful consideration the Oklahoma Chiropody Association voted unanimously to vigorously protest the release of any and all publicity of a change in name from Chiropody to Podiatry, to all news media, wire service, periodicals, radio and television networks and professional journals.

Also, the legality of the constitutional amendment, Proposition I, which was finally adopted by the 1957 House of Delegates is questioned.

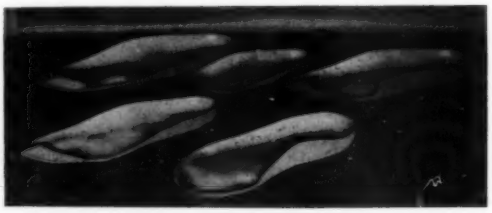
We further feel it can be proved by law they have no legal right to do several things they propose, as they would be usurping States Rights over State Legislatures, etc.

The Oklahoma Chiropody Association, Inc. is requesting an official "National Referendum" so that the profession may abide by the majority wishes honestly expressed and certified, and not the result of political action as displayed at the 1957 House of Delegates.

OKLAHOMA CHIROPODY ASSOCIATION, INC.
Howard Johnson, D.S.C.
Enid, Okla.

"But Abe, you still owe me for your inlays!!!"

ORTHOPEDIC FOOT APPLIANCES



Levy Moulds and foot moulds as produced by our laboratory are made for the particular condition, over individually corrected casts. They are indicated in most metatarsal conditions of mechanical origin, some toe conditions, foot strain, incipient pronation and heel problems of mechanical origin. Our inverting 'C' Moulds work especially well in controlling pronation in youngsters in the 1-6 age group.

Casts for moulds should be made with the plantar of the foot on a horizontal plane. If plaster strips are used, leave the dorsum of the foot and the tips of the toes uncasted to permit elongation when placing the foot in the plantar position.

Ours is the first laboratory to produce the Levy Mould. In cases with unusual problems write for suggestions as to procedure.

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Vice Admiral Ross T. McIntyre, U.S.N. (Ret.), former Surgeon General of the Navy, now Executive Director of the International College of Surgeons, is presented Honorary Membership in the American Podiatry Association. The dinner meeting honoring Dr. McIntyre was hosted by the San Diego Division of the California Association of Chiropodists.

Officers of the California Association present at the meeting were: Drs. Robert Jacoby, Lorenzo Johnson and William F. Eads. Among Naval Officers present were the Commandant of the Eleventh Naval District, Senior Medical Officers and Podiatry Officers of the Medical Service Corps, Lts. Gilbert and Dennis.

Presenting award, left to right, are: Dr. Charles R. Brantingham of the Executive Council of the American Podiatry Association, Vice Admiral Ross T. McIntyre, and the Commandant, Rear Admiral Charles C. Hartman, U.S.N.

ACCREDITED COLLEGES

California College of Chiropody
1770 Eddy Street
San Francisco, Calif.

Chicago College of Chiropody
1422 W. Monroe Street
Chicago, Ill.

Illinois College of Chiropody and Foot Surgery
1327 North Clark Street
Chicago, Ill.

New York College of Podiatry
53 East 124th Street
New York, N. Y.

Ohio College of Chiropody
2057 Cornell Road
Cleveland, Ohio

Temple University, School of Chiropody
1810 Spring Garden Street
Philadelphia, Pa.

CONVENTION DATES AND MEETING NOTICES

National Association of Chiropodists
Washington, D. C.
August 22-26, 1958
Shoreham Hotel

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Boston, Mass.
Oct. 17, 18, 19, 1958
Sheraton Plaza Hotel

Region Two
(New York)
New York, N. Y.
Feb. 21-23, 1958
Barbizon Plaza Hotel

Region Three
(Del., Md., N. J., Pa.)
Atlantic City, N. J.
April 17-20, 1958
Ambassador Hotel

Region Four
(Ohio)
Toledo, Ohio
May 17-18, 1958
Commodore Perry Hotel

Region Five
(Ill., Ind., Mich., Wis.)
Chicago, Ill.
March 21, 22, 23, 1958
Morrison Hotel

Region Six
(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Denver, Colorado
April 11-13, 1958
Cosmopolitan Hotel

Region Seven
(Idaho, Mont., Oreg., Wash., Wyo.)
Tacoma, Wash.
April 25, 26, 27, 1958
Hotel Winthrop

Region Eight
(D. C., N. C., S. C., Va., W. Va.)

Region Nine
(Florida)

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(Ala., Ga., Ky., Miss., Tenn.)

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Dallas, Tex.
June 19-22, 1958
Statler Hilton Hotel

Region Twelve
(Ariz., Cal., Nev., Utah)
Los Angeles, Calif.
May 30-31, 1958
Ambassador Hotel

American College of Foot Orthopedists
2nd Annual Scientific Session
March 20, 1958
Chicago, Ill.
Morrison Hotel

LEGAL AND LEGISLATIVE

NEBRASKA

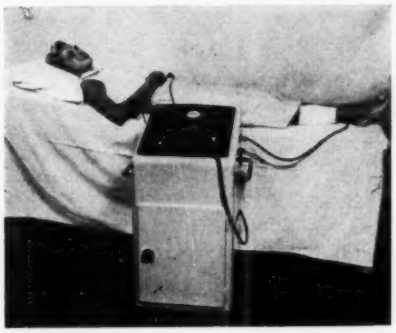
Attorney General for the state of Nebraska has ruled that the use of roentgen therapy by chiropodists for conditions they are licensed to treat is a permissible practice of a chiropodist.

NEW JERSEY

Because he was making plaster molds of the feet of an investigator for the purpose of fitting her with an orthopedic shoe, the party was brought before the Board of Medical Examiners in the state of New Jersey and charged with practicing chiropody without a license. Party entered a plea of guilty, was fined $150.00 and has ceased the practice.

VIRGINIA

The remark by an insurance adjuster to a patient stating that Dr. Graves, Richmond, Va., was not the type of Doctor for an injury to the foot, resulted in the Virginia Supreme Court awarding punitive damages against the insurance company. Record No. 4708, Supreme Court of Appeals of Virginia.



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Reports by Lyons, Meadows and Fuchs* indicate a vast improvement in circulatory disturbances by stimulation of the peripheral circulation with this new, more physiologic, electronic, mechanical device.

The Syncardon is designed to furnish pneumatic pressure impulses to an extremity for an exact, measured time in perfect synchronization with each pulsation from the heart. Thus, a local increase in intra-arterial pressure forces more blood through any small arteries and arterioles capable of dilation.

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2. Thrombo-angiitis obliterans
3. Acute arterial obstructions
4. Raynaud's disease
5. Diabetic arteriosclerotic disease

LYMPHEDEMA

1. Post-mastectomy edema of the arm
2. Non-inflammatory lymphedema
3. Post-inflammatory lymphedema

DISEASES OF THE VEINS

1. Chronic venous insufficiency
2. Varicose veins
3. Varicose and/or stasis ulcers

The treatment is followed by a remarkably prompt alleviation of pain, improvement in walking capacity, relief of intermittent claudication, and the healing of ulcers and gangrene.

* Lyons, Meadows, and Fuchs. A New Method for the treatment of Peripheral Vascular Disease. Southern Medical Journal, Volume 48, Nov. 8, Aug. 1955, Pages 811-819.

For Information, Write
SYNCARDON CORPORATION
OF AMERICA
Seymour, Indiana

MEDICAL RELATIONS COMMITTEE

The following Medical Relations Program has been suggested to each state society. It is based on a "grass roots" effort for improvement of medical relations. The philosophy behind this program is to allow medicine (grass roots medicine) to meet with us socially, be critical of our scientific advancement, as evidenced by our delivered papers, and to go away knowing that here is a profession that can offer much for the betterment of mankind.

The following approach is suggested for establishing better local medical relations on a nationwide basis.

1. Make an appointment with the executive secretary or chief executive officer of the State Medical Society. Ask his advice as to what he would consider the best approach to a better understanding of our profession. Listen intently and then offer the Medical Hospital A.P.A. exhibit for use at the next state medical meeting or convention.

2. A photograph of the exhibit will be necessary for perusal. This will have to be considered by the Medical Society executive board or exhibit committee.

3. Once the exhibit has been used and seen by a good many physicians you may continue your efforts to trying to arrange for a meeting with a joint conference committee of your states Podiatry (Chiropody) and Medical Society.

4. The next step should be an invitation to the State Medical Society members to a symposium as outlined.

Regarding the Exhibit: of necessity all schedules are booked through our Audio-Visual office. It is suggested that bookings be made 30 to 60 days in advance. There is no charge for the loan of the Exhibit; however, express or trucking charges are paid for by the recipient, from the last point of exhibition.

At the close of any showing the exhibit is placed in a reliable storage house. All storage charges are paid for by the A.P.A.

The approach is as follows:

1. The State Medical Relations Chairman must contact the Medical Society Chairman of Scientific Programs.

2. He must on behalf of his State Podiatry (Chiropody) Association invite the members of the State Medical Society to a scientific symposium on foot disorders.

(a) About 3-4 speakers or papers are to be read before a joint group of Podiatrists-Chiropodists and Physicians.

(b) Arrangements should be made for each paper to be reviewed by physicians and discussed for about five minutes.

(c) The moderator could be the Medical Relations Chairman.

(d) The program must be well planned three months in advance and approved by the Chairman of Medical Relations of the A.P.A.

3. It is suggested that the papers to be read must be new and well documented podiatric-chiropodical research of a clinical nature. They must hold some medical interest and excite the imagination of the scientific mind.

4. The papers may be award winning theses. They can be read by well informed podiatrists-chiropodists in lieu of the author's absence.

5. Where possible a pharmaceutical house may be invited to supply a repast of sandwiches, coffee and dessert as a professional relations gesture. This will swing pharmacy into the picture.

6. Our new exhibit on educational qualification should be displayed prominently and can be secured through the Audio-Visual Committee on reservation.

It is the hope that these programs will be inaugurated immediately. We have asked the State Societies to report their progress to the Medical Relations Committee.

Dr. Irving Yale, Chairman
Ansonia, Conn.

REPORT ON MEMBERSHIP

One of the most important phases of membership is our obligation to the future of chiropody.

We all treat students of grade school, high school, and college age who are floundering as to their future and life work. They simply do not know in what direction to turn their talents. What better opportunity do we have than to suggest "Chiropody as a Career." You will be surprised as to how many of these prospective students will express a great deal of interest in our profession.

In the first place they have a foot problem and have come to you for professional care. They have confidence in your ability or they would not be in your office. When you point out the fact of the great number of foot sufferers, and the few practitioners, they will be impressed. They will certainly see the obvious chances of success in chiropody, much greater than with any other branch of the healing arts. Give them the chiropodical literature which is provided for you from your Division, State, and National Societies. Ask your chiropody college to send them their brochure. The college will be more than willing to cooperate with you regarding any prospect.

In order to survive, our colleges must have students and our profession must have practitioners. If we provide the students, our colleges will furnish the chiropodists. Our problem is to provide qualified chiropodists to treat the vast number of foot sufferers who are all around us. The more chiropodists we have the more people will seek expert chiropodical care. We are proud of our profession and we should be happy to introduce "Chiropody as a Career" to qualified prospects.

Committee on State Society Membership
John C. Pankratz, D.S.C.
Meadville, Pa.

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This year, 3,500,000 American families, stricken by catastrophic illness or serious accident, face medical and hospital bills which will amount to more than 20% of their annual income. Further, over a million of these families will find medical expenses totaling more than half their annual income—and in some cases, an entire year's earnings.

If this happened to you, how would you meet the bills? Would you find it necessary to deplete your savings account, borrow on your life insurance, ask help from relatives or friends, make sacrifices for years to come? Only too often, when a catastrophe strikes, a long-cherished plan for future security and retirement is toppled like a house of cards.

Until recently, the only protection available to podiatrists and their families for medical and hospital bills was that afforded by Blue Cross-Blue Shield, the Basic Hospital-Surgical Endorsement to the N.A.C. Accident and Sickness Policy, or similar plans.

These are all excellent plans as far as they go. They provide payment toward the cost of room and board from the first day of hospital confinement, some miscellaneous hospital expenses, and for surgical fees on a scheduled basis. For a run-of-the-mill sickness or injury requiring hospital care, they cover the greater part of medical costs of a few hundred dollars. However, many serious illnesses call for costly medical and nursing services to be rendered at home, rather than the hospital. These are usually not covered by basic hospital expense plans. In a prolonged illness, or an accident causing severe injuries, much greater protection is needed.

To meet this very serious problem, the concept of Catastrophe, or Major Medical Expense Insurance at home or in a hospital, was developed. This new protection picks up where ordinary surgical and hospital expense insurance leaves off—and provides payment direct to the insured individual on an all-inclusive basis for medical, surgical, podiatric and nursing costs, both at home and in the hospital, as well as hospital room and board, even for a private room. Such costly services as blood transfusions, x-ray therapy, iron lung, antibiotics, the full fees for surgery (without a schedule limiting payment for each type), and special consultants (which are not usually covered under basic hospitalization insurance) are all provided for by Major Medical.

After long study and analysis of the plans offered by leading insurance companies, the Insurance Committee of the National Association, and our Insurance Counsellor developed a plan to fit the needs of A.P.A. members. This provides up to $10,000 to help meet the costs of a catastrophic illness or accident, for a premium well within the budget of members of the profession.

The plan uses the principle of a deductible amount, so familiar to all of us in automobile collision insurance. In this manner, the high cost of handling small claims is eliminated and rates can be maintained at a moderate level. Thus, after the first $500 of covered expenses incurred in an illness or accident is paid by basic hospital-surgical insurance (or by the member), the Major Medical policy will pay up to $10,000 of medical bills in and out of the hospital. Also, if a member's family is included in the plan and several members of the family are injured in a common accident, only one deductible amount of $500 is applied, but the $10,000 maximum is available to each injured person.

There are many other benefits included which make the N.A.C. Major Medical Policy outstanding. A brochure containing full details and illustrations of how the plan works, along with enrollment rules and premium rates, has been mailed to each member. This should be read carefully.

IRVING PASHIN, Pod.D.
Poughkeepsie, N. Y.

DEATHS REPORTED

Dr. Bradford Parker
Caldwell, Idaho

A. Jonas Berg
Poughkeepsie, N. Y.

A. Jonas Berg of The NAC Agency, Inc., Poughkeepsie, New York, passed away suddenly during the day at the Biltmore Hotel in New York on Tuesday, January 14, 1958. Mr. Berg served as Insurance Counsellor for the National Association since August 18, 1951, succeeding Arthur Dozois. He was well known to many members of the Association, having attended most of our meetings during the past years. Mr. Berg, who was 56 years of age, is survived by his wife, Margaret and two sons, Peter and William.

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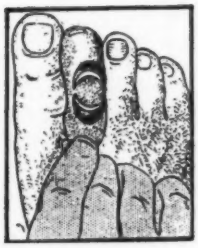
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TEN YEARS OF FOOT HEALTH WEEK

In May, 1947, Governor James E. Folsom (left) signed a proclamation designating Foot Health Week in Alabama. With him was Dr. Elizabeth P. Sealy, Secretary of Alabama Association of Chiropodists and Foot Health Week Chairman. Ten years later, almost to the day, the Governor and Dr. Sealy repeat the scene at the Executive's office (right) where he proclaimed the 1957 Foot Health Week in the state.

Foot Health Week this year is May 9-16, 1958. For some years now Foot Health Week has been sponsored by the American Foot Health Foundation. State Foot Health Week Chairmen should communicate with Dr. Sidney Hirschberg, President of the Board of Trustees of the American Foot Health Foundation, 107-07 Continental Avenue, Forest Hills, New York.

AN IMPORTANT ANNOUNCEMENT CONCERNING FOOT HEALTH WEEK FOR 1958

Foot Health Week, sponsored annually by The American Foot Health Foundation, will have a new look in 1958. Previous experience in conducting this week on the local level has proven too much of a burden for the individual chiropodist-podiatrist, as well as state and individual groups in the majority of cases.

This apparent lack of interest on the part of the profession in many quarters (as so often stated in the AFHF Annual Reports) has placed the Foundation in a position where it is forced to enlist the more enthusiastic cooperation and support of interests outside chiropody-podiatry itself.

The Foundation's efforts for Foot Health Week, which will run from May 9th to May 16th, inclusive, are therefore being concentrated on expanding the pilot program through industry which was begun last year. While this will remove the necessity for active participation by the individual practitioner, it will in no way curtail the same vast nationwide publicity and public education program so successfully conducted last year by the Foundation. This phase of the Foundation's operation of Foot Health Week should not detract in any way from programs already started on a local level, but, in fact, may do much to

give added impetus to such endeavors. The Foundation will supply whatever specialized material we have available for assisting in these local programs, at cost, upon request.

The Foundation will shortly announce, through the Journal of the American Podiatry Association, and to all State Secretaries, the establishment of an important new annual special event to take place throughout the nation in October of each year, starting in 1958. This program will directly involve active participation by the individual doctor. This event will be called (tentative title) "Youth Foot Care Week." It is a highly systemized adaptation for already proven practices of conducting foot examinations for children. It will be backed by a vigorous nationwide educational campaign by AFHF. Details of this significant event and how to participate will be announced in the March issue of the Journal of the A.P.A.

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INDUSTRIAL RELATIONS COMMITTEE REQUEST FOR INFORMATION

The need for the entry of our profession into the industrial health field is more important today than ever before. We must become increasingly aware of the fact that our survival as a profession must be considered in light of health insurance plans and industrial care. The private patient is constantly becoming a smaller group, and the tremendous yearly increase of health insurance points to the fact that most Americans will soon be covered by some type of a prepaid plan. We as a profession must be prepared for this eventuality in order to substantiate our existence as an intricate and recognized part of the healing arts.

This most important facet of our public relations is sorely in need of vital statistics and information to tell the story of Industrial Podiatry, why our services are needed, and the varying degrees with which the incorporation of Podiatry within a medical health program can decrease absenteeism, increase efficiency, and cut down on accident rate, etc. These facts at the present time are not available. It is the hope of our committee to tell the story of Industrial Podiatry in the form of "An Approach Brochure to Industry."

It is hoped that through your cooperation we might soon be able to present the initial phase of a "broad spectrum" Industrial Health Program.

Dr. John E. Green, Chairman
Industrial Relations Committee

It is essential at this time that all those associated with industry fill out the following:

FILL IN AND MAIL IMMEDIATELY

1. Name _____
2. Address _____
3. Name of industry, manufacturer, retail corporation, union, etc., associated with _____

   Address _____
4. Number of employees: Male_____ Female_____ Total_____
5. Do you have any statistical data on your industrial podiatric work?
6. Do you have or can you obtain laudatory testimonial comments on the advantages derived from your work?
7. Would you be willing to use standardized examination cards from which to obtain vital statistics?
8. Could your particular concern be used to conduct a "pilot study" to determine the value of Industrial Podiatry within the Medical Health Program?

Mail answers direct to:

Dr. Michael Dickman (Statistical Analysis and Evaluation)
725 Scotland Road
Orange, New Jersey

WOMEN'S AUXILIARY

President's Address

It is with a sense of great humbleness that I am assuming the position as your President. Needless to say, I am counting on each and every one of you to be my personal assistant this coming year.

May I take this opportunity to sincerely thank Miriam Shor for her tireless effort during the past two years. I know I shall have to strive very hard to compare with her accomplishments. May I say that I will do my utmost to increase our organization, uphold the standards of our husbands' profession and further educate people to the value of chiropody-podiatry.

What can we set as our goal for our year just beginning? Will it be more members for our Auxiliary? Further education as to the value of our husband's profession? What we decide to do is only important if we can definitely accomplish something. No matter how insignificant it may seem to us—we must remember each small accomplishment is a definite step forward, especially when multiplied by the number of our members. If each of us would decide to accomplish one thing for our auxiliary this year think of the tremendous value it would be, not only in the satisfaction of having reached a goal, but also the feeling of having assisted our husbands.

For one thing—remember our service in our community is the best public relations factor that we have. There are many available sources for us to work with if we will put forth a little effort. Volunteer to take an office in your P.T.A., your Women's Clubs—or be a good committee member. Just remember you will be noted as the wife of Dr. Jones, etc. Make your presence noted and what is more important—wanted. When asked to serve try not to say, "I don't have time," but try to make time to do your service to your community.

Remember the old adage "Put Your Best Foot Forward?" What could be more appropriate for us?

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MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.

A.O.P.

The boss's instructions to the foreman were to have the gang dig a certain line of holes, then fill 'em again. The boys did as ordered but every time they filled a hole there was dirt left over. The foreman studied the situation a long time and finally came up with, "The only thing I see to do Boys, is to dig the holes deeper."

Traffic Cop: "Why did you keep going after I whistled?"

Driver: "Sorry, I'm pretty deaf."

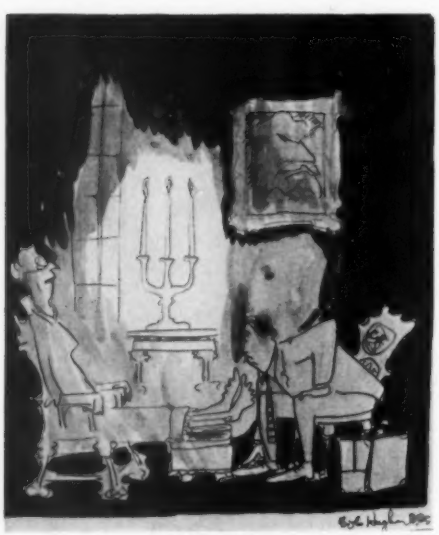
Traffic Cop: "Well, don't worry, you'll get your hearing in the morning."

Junior Devil: "Heh, heh, heh."

Satan: "What are you so happy about?"

Junior Devil: "I just locked a woman in a room with 1,000 hats and no mirror."

An Optimist: A man who marries his secretary thinking he'll still be able to dictate to her.



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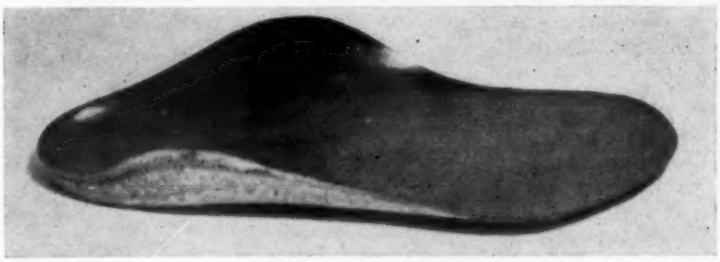

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WANTED: Your scientific exhibit for the program of the Western Chiropody Congress in Los Angeles, California, May 30, 31, 1958. No exhibit too small. Interested? Write for details. Dr. S. E. Levy, 133 South Lasky Drive, Beverly Hills, California.

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